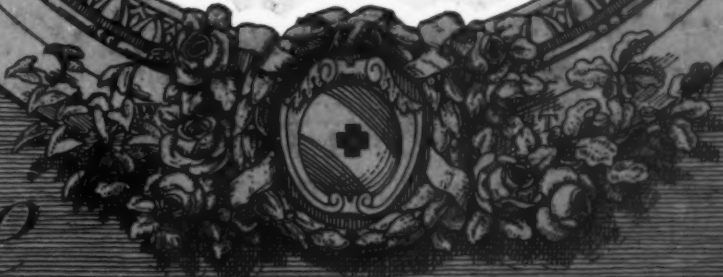
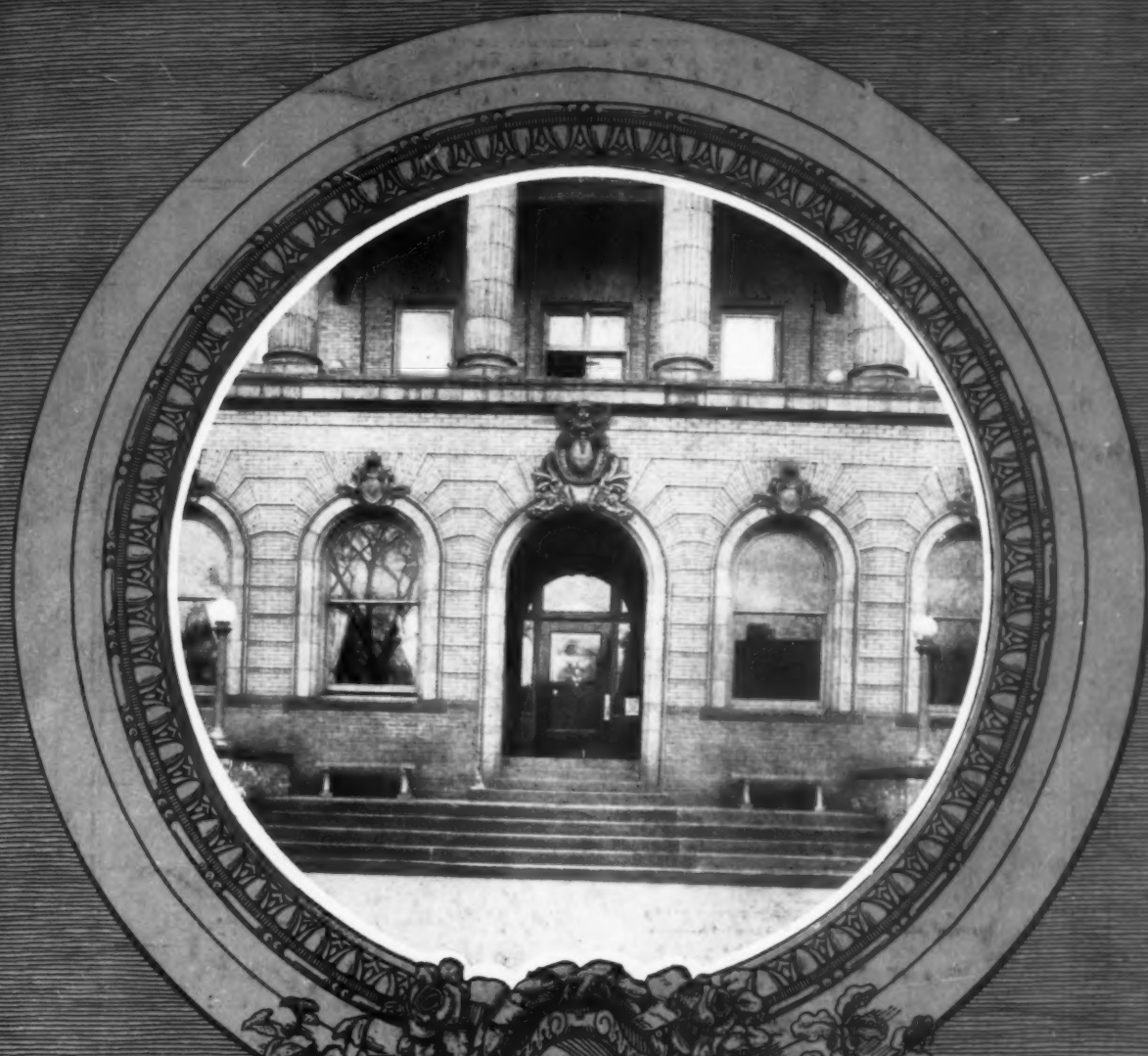


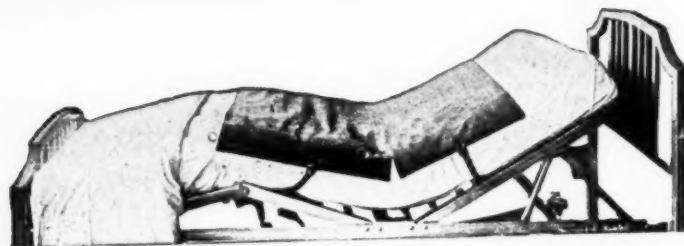
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THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment and Administration of Hospitals, Sanatoriums and Allied Institutions, and to Their Medical, Surgical and Nursing Services

Vol. XXIX

October 1927

No. 4

HOLDING THE MIRROR TO OUR COSTS AND CHARGES

By Frank E. Chapman, Director, Mount Sinai Hospital,
Cleveland

ARE American hospitals mismanaged? Is there a less return for the dollar as it is expended in hospitals than when spent for other necessities? Is the charge for hospital service mounting out of proportion to its costs? Are American hospitals creating a burden for the sick that is unjustified? Is the charge to the middle-class patient beyond the ability of the patient to pay?

The foregoing questions and others that are similar are being presented to the hospital field with marked frequency and demand that a conscientious attempt be made to ascertain the pertinent facts. Human nature is prone to accept reiterated statements and the lay press has carried to too great a degree statements bearing upon the inefficiency of hospital operation in this country.

In a large measure American hospitals are administered with more than the average degree of proficiency. General statements of comparison are always misleading and are seldom founded

HOSPITALS are not inefficiently managed. Service for service and cost for cost hospital operation throughout this land will compare favorably with that of any type of activity that is in any measure comparable. Hospitals have not increased their cost of operation out of proportion to the natural upward trend in the cost of living. Hospital charges are not out of proportion to hospital costs. Even in an institution admittedly operating for profit the percentage of profit is not out of line with profit made by industrial activities. Let the hospitals of this country recognize these facts and let them combat by every means in their power some of the ill-advised statements that have been made, statements that are not predicated upon established facts.

upon specific facts. It is, therefore, the purpose of this article to present to the hospital field for its consideration, information based upon recorded facts, the result of an analysis of approximately two hundred representative hospitals in all parts of the continent.

Colonel L. P. Ayres, economist of Cleveland, is our authority for the statement that the index figure for the cost of living for the year 1926 is 175.6 as compared with 100 in the year 1913. This index is based upon figures of the United States Bureau of Labor Statistics. Colonel Ayres submits a further index figure of 167.1 furnished by the National Industrial Conference Bureau, the latter figure representing the average for the year. The first figure represents

the index as of December thirty-first of each year. For the purpose of this article it is a matter of no moment which index figure is used for comparison. They are merely presented to show, from the best sources possible, the relative increase in

the cost of living during the periods under comparison.

The accompanying tabulation shows the increase in the cost of hospital service as represented by the annual reports of approximately one hundred fifty hospitals, divided into three geographical groups in the eastern, central and western parts of the country. Rather than show the complete tabulation of these figures there is presented the highest percentage of increase in cost, the lowest percentage of increase in cost, and the mean average percentage of increase in cost.

	Eastern States	Central States	Western States
Highest percentage	250%	218%	75%
Lowest percentage	40%	29%	48%
Mean average percentage ..	119%	108%	61%

Statistics without an intimate analysis of their makeup can be indicative only of general trends, and in no sense of the word may they be used as a final index. The mean average figure means little. Let us take the eastern group of hospitals as an illustration and analyze in detail the increases in these institutions.

Thirty-two hospitals are included in this group, all of them general hospitals. The highest increase in the cost of hospital service occurs in an institution that has completely revamped its accounting system in the last five years, and admits a lack of accurate knowledge of true cost of operation in previous years. This particular hospital shows an increase in cost of operation of 250 per cent. Five of these thirty-two hospitals show an increase of 150 per cent or more. More than fifteen show an increase between 100 per cent and 149 per cent. Thirty-eight per cent of these hospitals show an increase of less than 100 per cent in their cost of operation in the period of years under discussion.

The purpose of detailing this information is to call attention to the fact that the mean average shown here is as a matter of fact not indicative of the real situation because of the high increases produced in approximately three instances, only one of which the author is able to explain.

The reports on which this article is based were received in response to the following letter: "We are anxious to know what your costs per day were in 1913 and what they are today; what your rates for ward beds and private rooms were then and now and the average length of patients' stay at both times? Will you also enumerate the various special charges that have been added since 1913?"

"This information is to be the basis for an article by which we hope to prove that hospital charges are not exorbitant but on the contrary are very reasonable."

The hospitals to which this letter was sent were chosen for several specific reasons; first, they must have been in operation since before 1913; second, they must not be government supported but must be general hospitals with the usual salaries and expenses paid to all executives and department heads; and, third, they must not be too large for comparative purposes or too small to represent the general trend.

In all probability a more accurate knowledge is obtainable today as regards accounting performance than was obtainable in 1913. If this is so, it seems logical to state that in all probability the cost per patient per day submitted as of 1926 may not in fact indicate the real increase in the cost for service as compared with 1913 to the degree that it does show, but that a portion of this increase may be accounted for by a more accurate method of recording hospital performance. In any event, let us accept it as a fact that 119 per cent for the eastern states, 108 per cent for the central states and 61 per cent for the western states represent the mean average of increase in the cost per patient per day, and let us definitely compare this increase with the increase in the cost of living as given by an unquestioned authority on the subject.

What Elements Influence Cost?

In making these comparisons the reader should analyze for himself the various elements entering into the cost per patient per day, so that there may be no misapprehension as to the basis for this increase. First of all, do not forget that in 1913 the twelve-hour or fourteen-hour day was the rule rather than the exception, and that the seven-day week was an accepted practice in all hospital operation. This picture has changed completely. The hospitals have rightfully adopted, to as great a degree as is possible, at least the forty-eight hour week, and in many instances the forty-four hour week, for their personnel. Do not overlook the fact that the scale of compensation paid hospital personnel has been undergoing a rapid upward trend in the last few years. This has been definitely demonstrated and presented in studies of various key positions in the hospital field, and is true to even a greater degree in the rank and file of hospital personnel. Both of these factors are absolutely beyond the control of the administrative officers of hospitals, and are changes that without question are justified and should have been made effective many years ago. They have, however, produced an entirely different ratio of operating expense.

Fifteen years ago approximately 30 to 40 per cent of the total cost of hospital operation was

pay roll expense. Today that ratio is between 45 and 60 per cent. Therefore, when we take an index of the increase in the cost of living, we must bear in mind that this represents but 50 per cent of the cost of hospital operation, and that the other 50 per cent is subject to a relative increase far beyond the index provided by Colonel Ayres.

Fifteen years ago the ratio of personnel to patients was approximately six to one. Today studies of this ratio will produce the startling figure of 1.7 to one in any number of efficiently managed hospitals. This in part is due to reduction in the number of hours of labor required. The real reason for this increased ratio of personnel to patients, however, is the increased demand for supplemental facilities to clinical practice of medicine.

Fifteen years ago hospital service entailed nursing care, dietary care and a reasonable amount of housekeeping, mechanical and administrative personnel. Today the picture is completely changed. A large number of technical assistants to the clinical staff, the increased ratio of nurses to patients, by reason of a more complex nursing procedure, brought about in turn by the increased demand of the physician, have necessitated the inclusion on the pay roll of personnel never dreamed of fifteen years ago.

It is interesting to compare the increase in the rates charged for hospital service between the year 1913 and the year 1926, and to make a further comparison between the increase in the cost per patient per day, and the increase in the charge per patient per day for these two periods.

Increase in Rates Charged to Patients

	Eastern States	Central States	Western States
<i>Ward Rates:</i>			
Highest percentage	300%	200%	70%
Lowest percentage	18%	20%	25%
Mean average percentage	99%	87%	48%
<i>Private Room Rates:</i>			
Highest percentage	265%	178%	25%
Lowest percentage	25%	25%	10%
Mean average percentage	76%	66%	18%

In none of the three groups under consideration did the increase in rate for wards or private rooms increase in proportion to the increased cost per patient per day in so far as the mean average increase is concerned. It is true that in the eastern group one institution showed an increase above the increase in its cost per patient per day. However, this is but one instance, and it is one that again influences the mean average increase upward rather than downward.

It is difficult to make a specific statement as to

the degree of increase in special charges, but it is probably true that the practice of assessing special charges in 1913 was not as universal as in 1926, at least in degree, and that therefore the basic room rate increase may not be a fair index of the increased charge to the patient. An analysis of the ratio of special charges to total income, made in the city of Cleveland, indicates that approximately 30 per cent of the total income from patients in hospitals making special charges is received from special charge items rather than from basic room rate. Let us accept this ratio as sound, and discuss the question of income from patients with this percentage in mind.

Accounting for Special Charges

To be fair, let us assess one half of these special charge items to the mean average figures shown, and a favorable comparison may still be made between the increase in the cost of hospital service and the increase in the cost for charges made for hospital service. The other half of the special charge item of 15 per cent of the total cost of hospital charges will be accounted for in another paragraph of this article.

In the study of hospital statistics an attempt was made to include an analysis of the average stay per patient per day in the institution, and a conservative resumé of these figures permits the statement that, at a minimum, patients were discharged from hospitals at least four days sooner in 1926 than in 1913. Figures submitted by some hospitals indicate a saving much higher than this. In some few instances the saving is lower. There is no desire to accept extreme instances and four days is an extraordinarily conservative estimate of the average lower patient-day stay.

Let us accept as the productive value of an individual \$4 per day, which is unquestionably low. A mathematical problem immediately presents itself that will answer conclusively whether or not the patient actually has, in hard cash, paid out more than he did in previous years, discounting entirely the gain obtained by a return to productivity at an earlier period. It is reasonable to assume that with improved methods of therapy the patient today convalesces more promptly and is returned a productive unit to the community quicker than fifteen years ago. Therefore, in addition to the actual out of pocket expense being relatively no higher (disregarding the change in the purchase value of the dollar) you have an individual more quickly returned to productive work, with a consequent improvement in financial status.

After all, is it the prohibitive cost of health

service that we must combat, or is it the resentment of the expense entailed in combating disease that we must resent? It is interesting to analyze the change in point of view between an individual asked to go into the hospital at \$10 a day and that same individual going to a summer resort at the same rate or more. It is interesting to compare the demands made for the purchase of luxuries and the demands made for the purchase of health, and the philosophy of the individual meeting these two demands. The law of averages must of course prevail. It is reasonable to assume, judging from statistics, that an average family of five will have a hospital experience once in two years. Let us grant an average stay of twelve days. Let us grant a charge of \$10 per day for the hospital plus \$5 per day for extra charges, plus \$10 per day for doctors. These are all above the average charges. There is produced a budget for health in this family of five, of \$150 per year or \$12.50 per month. Is this excessive? This same expenditure, without any question, would be made by any family in the group we are discussing, for absolute non-essentials without any quibble.

It seems to me that we who are responsible for operation of hospitals should change our own mental process just a little, and should cease to be apologetic for our hospital charges. We should actively combat through every means in our power this growing feeling that hospitals are overcharging; that hospitals are inefficient. Comparisons with other activities would be good for our souls, and would improve the understanding of our boards of trustees.

Go to the best hotel in your community. Get the real facts about its operation. Ascertain its raw food cost per meal. Ascertain its service cost per meal. Find out how many square feet of floor space each one of its maids covers. Know what its administrative cost is as compared with its total cost of operation. Then come home and compare these figures with your own costs, and I

believe you will not compare unfavorably, no matter where you are.

There is a growing resentment among hospital administrators of statements that are designed to make harder the path of that large group of men and women working under exceedingly grave handicaps, seldom with sufficient funds to do the things that should be done to improve their standard of service.

Let us now face about and view the problem from another angle. First of all, let us admit that hospital expense is trying even to a patient

who need have no thought whatsoever of the cost. It is doubly so for the individual who must of necessity conserve his income to the greatest possible degree. Let us admit also that there are many avenues of waste in hospital operation, as there are in every other activity. Let us still further admit that by the very nature of the service that a hospital renders these avenues of waste are, in all probability, greater than they are in most activities. These things are inherent in a large measure in the type of work to be rendered, and are the greatest problem of the efficient hospital administrator.

There then presents itself the problem of

how to reduce to a minimum the cost of hospital operation by conservation of money, so that the service to the patient can be rendered with a greater degree of proficiency for a like amount of money expended. Let us now consider various procedures that may assist the administrator in the problems presented.

Program of Operation

The above heading is used to get away from the use of the term "budget." There are those who resent the statement that a hospital can be budgeted. This resentment probably results from a lack of understanding of what a real budget means. After all, a budget is nothing more or less than an attempt to plan in advance intelli-

IT IS reasonable to assume, judging from statistics, that an average family of five will have a hospital experience once in two years. Let us grant an average stay of twelve days. Let us grant a charge of \$10 per day for the hospital, plus \$5 per day for extra charges, plus \$10 per day for doctors. These are all above the average charges. There is produced a budget for health in this family of five, of \$150 per year or \$12.50 per month. Is this excessive? This same expenditure, without any question, would be made by any family in the group we are discussing for absolute non-essentials without any quibble.

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gently for a period of operation, instead of going along in a hand to mouth fashion without any plan for future service or any knowledge of what may be expected in the way of funds. Such a policy is ridiculous. It can only be productive of harm to the service of the hospital and will produce a day of reckoning for the administrative officer.

How much better and how much sounder it is to make an intelligent study of the problem, to establish certain goals and to prepare a plan for attaining these goals. There are, of course, in every institution emergencies that must be met. These cannot be anticipated, but it is reasonable to assume that there must always be provision for extraordinary things, and any program of operation that does not contemplate these extraordinary demands of service and consequent extraordinary demands of expense is faulty in its preparation.

By far the most important job of the hospital administrator is the preparation of this program of operation, and the establishment of such procedures as will insure to that administrative officer an accurate knowledge of the day by day performance of his hospital, so that he may know to what degree he has attained the standard that he has established for himself.

Daily contacts with department heads, personal inspection of the institution in order to insure a first-hand knowledge of actual conditions are prerequisite to an understanding of the problem. Daily reports covering the major activities of the organization, currently posted in comparative form, so that at any time comparisons may be made, should be an integral part of the armamentarium of any administrative officer in a hospital.

An analysis of purchases by departments, so that the standing of a particular account may be known before the purchase is made, and, still more important, an intelligent analysis of issuance of supplies, so that every unit of the hospital may have those things that are necessary for proper service without waste, these are essential factors in a program of operation.

Monthly reports of operation, not made in a

routine manner but designed with a specific purpose in mind and used as designed, should be presented to the administrative officer and to his department heads, so that they may be informed of the progress of the hospital. These are the things that make up a program of operation and promote its proper functioning, and these things, if properly conceived and consistently followed through, will produce an efficiency of operation far beyond the fondest dreams of their creator.

There are eight major divisions of hospital income. Each of these is not applicable to all hospitals, but all hospitals must rely on some of these for their support.

It is the natural impulse to keep the rates of our hospitals at the lowest point consistent with good practice. None of us want to raise our rates.

Such a feeling is to be commended, but if these rates are established without a knowledge of the cost of hospital service, curtailment of service to the patient or an unsatisfactory financial condition for the hospital will result.

In many instances hospitals have not established rates on a sound basis. It is not hoped to make hospitals self-supporting. The ratio of free and part pay work that most hospitals do precludes

such a status, and therefore subsidized income is necessary in a large number of our institutions. The philosophy of subsidized income for hospitals is eminently fair so far as the indigent are concerned, and so far as individuals who are not indigent who cannot pay full cost of care are concerned, but the policy of a great many institutions of rendering service in private rooms at less than cost is not justifiable, nor is it for the best interests of the patients.

It seems reasonable to demand that a patient occupying a private room shall pay cost of care plus a reasonable degree of profit. There is no more reason why the hospital as much as any other type of activity should not obtain profit for its service. This profit should not amount to exploitation, but it must not be lost sight of that few hospitals actually charge into their operating cost their entire cost.

Practically all hospitals are the recipients of endowed services, either in the form of the con-

AFTER all, is it the prohibitive cost of health service that we must combat, or is it the resentment of the expense entailed in combating disease that we must resist? It is interesting to analyze the change in point of view between an individual asked to go into the hospital at \$10 a day and that same individual going to a summer resort at the same rate or more. It is interesting to compare the demands made for the purchase of luxuries and the demands made for the purchase of health, and the philosophy of the individual meeting these two demands.

struction of the building, through the generosity of the community, or in the form of actual out-and-out gifts for specific operating purposes. Therefore, it would seem that the hospital administrator should know the cost per patient per day of his institution, should establish a minimum rate for his private rooms, at least 10 per cent higher than the cost per patient per day, on the premise that lack of occupancy of the room, collection failure and similar items will just about offset this 10 per cent increase.

Facilities for semi-private patients should be based primarily, of course, upon the approximate ability of patients to pay, and in keeping with the usage of each community. These part pay patients represent the largest group to be served in any community, and the hospital that does not accept its fullest responsibility toward this group of individuals is failing greatly in its community obligation.

Ways to Increase Earnings

A careful supervision of the status of patients' accounts by the administrative officer or by someone detailed to do this work, will from time to time demonstrate ways and means of increasing earnings from patients, and more important still, will improve the collection performance of the hospital. There might be placed on the administrative officer's desk each morning a statement from the cashier's office showing the number of patients admitted during the previous twenty-four hours, who have failed to make satisfactory arrangements in advance for the liquidation of their accounts. A further statement as to the number of patients leaving the hospital who have not liquidated their accounts is also valuable. The psychological effect on the collection department of a statement of this kind being placed in the administrator's hands cannot but produce better results.

There has been a great deal of discussion for several years as to what shall be the hospital's policy with reference to the collection of accounts. The development of earnings from patients will be discussed here merely as an incidental phase, and only one or two points will be outlined that may be helpful to the administrator.

The collection experience of the Cleveland Hospital Council has shown conclusively that a large part of the collection failure in hospitals has been caused by a failure of the individual hospital properly to acquaint individuals with the practice of the hospital, failure to secure complete collection data, and, equally important, the placing of patients in accommodations the price of which is entirely beyond their ability to pay, with the

result that they leave the hospital with unpaid balances. A proper collection performance cannot be obtained unless the admitting room performance of the institution is accurate in all of its details. Patients upon admission should have explained to them fully that hospital bills are payable in advance, what the rate will be, what special charges will be. The admitting office should also make a sincere effort to place patients in accommodations that are within their ability to pay. The admitting office should also, as a matter of routine, obtain full information, including the correct name of the patient, the correct address, the name of the individual responsible for the account, the signed guarantee, if possible; that is, the office should get such data as will permit of an intelligent follow-up of the account in the event payment is not made in accordance with contract.

There are several types of collection procedure and there is no desire in this article to go into detail regarding them. With reference to the relative merit of various types, it may be said that the collection of hospital accounts to be efficient must be made, if possible, during the patient's stay in the hospital. If this is not possible, there must be established immediately upon the patient's discharge a routine method of follow-up of the account, calling it to the attention of the individual responsible for the bill, and insisting upon specific arrangements being made either for the immediate payment of the account or for current payments in partial liquidation. The trouble with hospital collections is that this matter is often relegated to someone as a secondary duty, and no attempt is made to follow up the collection until several weeks or months have elapsed after the patient has left the institution. Such a practice will not be productive of good results.

Should Legal Methods Be Used?

There seems to be a question in the minds of some as to whether hospitals should use legal methods for the collection of hospital accounts. The hospital obligation is just as binding upon an individual as is an obligation for the payment of purchases of any commodity. Assuming that the hospital has used intelligence in the assigning of patients to facilities that they can afford to pay for, and assuming further that the patient as a responsible person has accepted responsibility for the account and has made definite agreements to pay the account, there is no good reason why the hospital should not use any legitimate means for compelling the fulfillment of the obligation.

There is no question that resorting to courts of law is a drastic measure, and should be considered

only after every other method has been exhausted. However, if in the mind of the administrative officer the individual can pay the account, then it seems logical to compel him to do so, even through the process of suit.

In some political subdivisions there is an arrangement whereby hospitals are granted a subsidy either on a per diem basis or as a lump sum for the care of indigent sick. I know of no instance where this subsidy extends to the care of the deficit created by loss on part pay patients. This medium of income in most instances is, as a matter of fact, not adequate to meet the actual cost if, on the per diem basis, the per diem rate established by the political body is generally below the cost of care. It seems desirable that administrators by group action should attempt to demonstrate to those responsible for the establishment of these subsidies the principle that these subsidies should be on the basis of per diem cost. This question is an eminently proper one for the state hospital organizations to take up as a primary program. Collective action on the part of hospitals of the state will have greater weight than discussion entered into by only one or two hospitals.

A great many hospital administrators will testify to an unusual success in the securing of individual donations for operating deficits. These need not necessarily be large sums of money. By propaganda it is possible to get a given community into the habit of giving small donations direct to the hospital. The giving of money to hospitals in memory of departed friends in lieu of flowers has been productive of large amounts of money to some institutions. The commemorating of happy events by the giving of donations to the hospitals works no particular hardship on the donor and the result is helpful to the hospital. Hospital administrators should devise ways and means to stimulate this practice in their individual communities.

The community chest idea of financing social service work is undoubtedly the most efficient financial scheme in communities served by a community fund for producing subsidized revenue for

hospitals. In the minds of some is the thought that to relieve the individual hospital of financial responsibility for deficits and to place this responsibility on the community fund is apt to stimulate a disregard of small economies and create large operating deficits. This may be true if the community fund is not administered soundly, but all in all it seems that this method of financing social activities will become increasingly important as those agencies now in existence further demonstrate their ability to meet the needs of the situation.

The oldest method of creating subsidized income is the establishment of as large an endowment as possible, the principal of which is to be conserved and only the interest used for operating expenses. There are those who will contend that each generation should take care of its own and that therefore the creating of endowments is unsound and produces a burden that should be shared by future generations. On the whole, this is not particularly sound reasoning. Hospitals seldom, if ever, have sufficient funds to meet their operating needs, and if it is feasible to

DO NOT overlook the fact that the scale of compensation paid hospital personnel has been undergoing a rapid trend upwards in the last few years. This has been definitely demonstrated and presented in studies of various key positions in the hospital field, and is true to even a greater degree in the rank and file of hospital personnel. Both of these factors are absolutely beyond the control of the administrative officers of hospitals, and are changes that without question are justified and should have been made effective many years ago. They have, however, produced a different ratio of operating expense.

develop an endowment relieving the administrator in part of his financial burden and permit of funds being available for research and for the introduction of new phases of service, it seems desirable to do so.

Some contend that health is as basic as education, and that therefore health should be returned on the tax duplicate just as is education, with the result that those who desire to do so may present themselves to a publicly supported hospital and may receive adequate medical care. This condition of affairs may exist in Utopia, but it is questionable if on the Western Hemisphere we shall ever reach this state of existence. As a matter of fact, it is questionable if it is desirable that we ever should reach this state of affairs. There will always be need for the tax-supported hospital. Unquestionably the community through its government should assume responsibility for the indigent, and in all probability should assume responsibility for the care of the part pay patient, either by the maintenance of its own hospitals or

by subsidy of private hospitals. If the former condition exists, it seems incumbent upon the community to insist that these tax-supported hospitals assume their full obligation and that they be operated with a standard of service in keeping with the standards of service established by the private hospitals. It is especially true that the government agencies should maintain facilities for combating public menace, such as contagious disease. These types of cases are seldom cared for adequately or properly by the private hospital. If the government hospitals are properly operated they will relieve private hospitals of a great burden and will permit the allotment of their funds to the services that will make the hospital service of the community more inclusive than would be possible if the government agencies did not function.

Group Health Insurance May Come

Much discussion has arisen of late years as to the desirability of establishing group health insurance with hospital agencies, such as has been in effect in many corporations, particularly the railroads, for a great many years. It may be that some day someone will work out a plan whereby this can be brought about. If it were to be possible to underwrite hospital expense on an equitable basis for various groups in a community, it certainly would relieve the hospital of a great financial burden and would also relieve the individual family of an expense that is seldom computed in its operating budget. That day has not come yet. The subject is brought up here merely to call attention further to the necessity for increasing the sources of income for our hospitals.

The cost per patient per day for hospital operation will probably become increasingly greater as medical practice makes increasingly heavy demands on the hospital for service. It is reasonable to assume that as methods of diagnosis and therapy become more complicated and as the hospital assumes an increasingly important role in the health program of the community, the cost of operation is going to increase. Perhaps the most acute problem facing the hospital field today is the development of ways and means of increasing sources of revenue. In the January, 1927, issue of *THE MODERN HOSPITAL*, leaders in the hospital field gave their views as to what is the greatest problem in the field, and without exception in one form or another the question of income was dwelt upon.

Hospital administrators must cease to be technicians; they must be leaders in fact as well as in name. They must not confine their activities within their institutions or devote their energies

to routine tasks. They must rather so plan their days' work as to permit of continuous analysis of various procedures within the institution, to the end that they may be able to establish economies that it is not reasonable to expect can be established by department heads. They must constantly have their fingers on the pulse of operation, to feel the changes that are occurring within their organization. With an intelligent understanding of the problems of their organization produced by consistent study of its needs, they will be equipped to meet the demands of these changes better than if they conceive it as their job to do some technical piece of work that can better be done by someone else.

Hospitals are not inefficiently managed. Service for service and cost for cost hospital operation throughout this land will compare favorably with that of any type of activity in any measure comparable. Hospitals have not increased their cost of operation out of proportion to the natural upward trend in the cost of living. Hospital charges are not out of proportion to hospital costs. Even in an institution admittedly operating for profit the percentage of profit is not out of line with profit made by industrial activities. Let the hospitals of this country recognize these facts and let them combat by every means in their power some of the ill-advised statements that have been made, statements that are not predicated upon facts.

"CONSISTENCY THOU ART A JEWEL"

We will pay \$200 to renew our winter wardrobe, and complain of half this amount spent to restore our health.

We will pay seven dollars a day for a room at the best hotel, and call the same amount robbery when charged by the hospital, even though board and nursing are thrown in and no tips expected.

We will pay heavily for amusements, and then allow ourselves to accept the charity of others in matters of personal and public health.

We will lay up \$300 for a modest summer trip, but won't think that the hospital is modest at all if that is all it charges for a trip to the operating room, even though we readily acknowledge that it added years to our lives.

We will pay \$1,095 for a new car, and then apologize for buying "a cheap one;" but \$1,000 for the skill and weeks of care necessary to save a favorite child looks "outrageous."

We will strain our resources to provide a respectable funeral for a relative or penniless friend, but will not make an effort to provide the financial assistance that might have made the funeral unnecessary.

We will be too proud to ask aid from parents, brothers and sisters, but not too proud to ask a stranger to carry our financial burden, without even interest on the money, just because that stranger is a doctor or the business manager of a hospital.—*Bulletin of the Christ Hospital of Cincinnati.*



DE LUXE FEATURES ARE INSTALLED AT MEYER HOUSE

By Carl A. Erikson, Schmidt, Garden & Erikson, Architects, and Herman Smith, M.D., Superintendent,
Michael Reese Hospital,
Chicago

MEYER House is the gift of the children of Max A. and Sarah F. Meyer to Michael Reese Hospital, Chicago. The purpose of the gift was twofold: first, to release private rooms in the main building of the group for use by private ward patients, and, second, to furnish adequate facilities for private room patients.

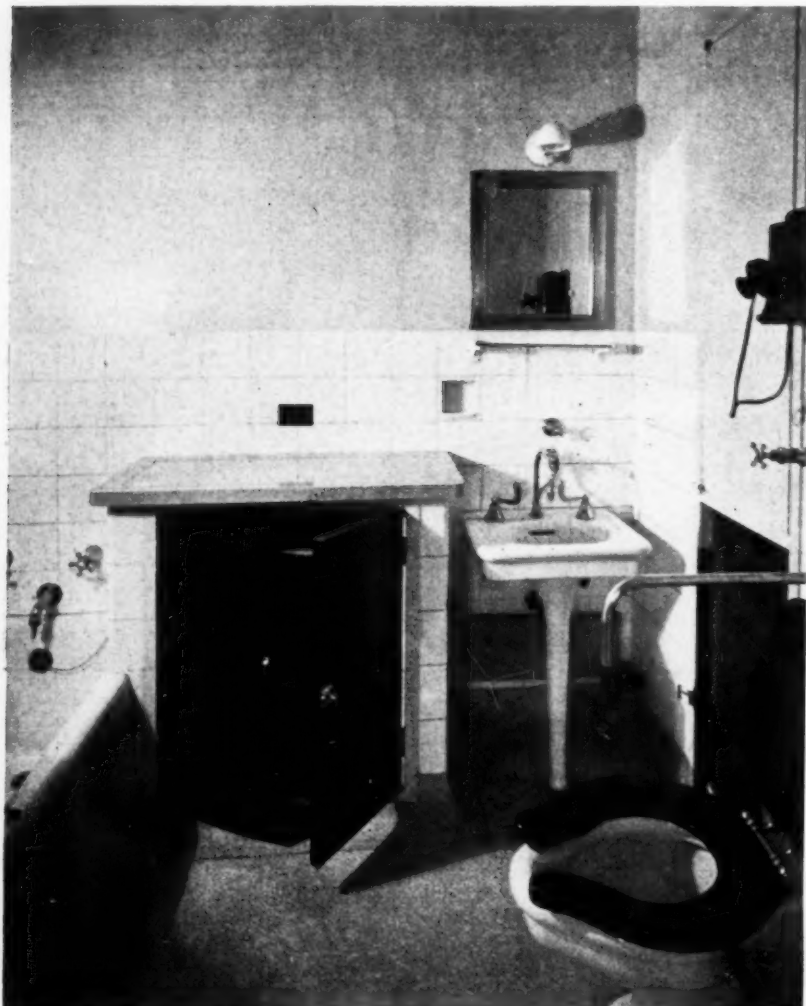
The donors saw clearly the outstanding need for increased accommodations for the so called middle class patients, who, in most instances, have either to accept charity in the free wards of hospitals or go beyond their financial depths in attempting to meet the ordinary private room charges, with their concomitant extras. Although there were formerly eighty-six adult private ward beds in Michael Reese Hospital, in a total of 475 beds, through the erection of Meyer House and the building changes incident to it in the main building, there will be an increase of nearly 50 per cent in private ward accommodations.

In carrying out the second purpose an attempt

was made to have available for the patient and the personnel caring for the patient, every convenience that modern medicine and nursing demand; and, while having these conveniences readily accessible to the patients, at the same time to make the patients' surroundings homelike.

The site available was ninety by one hundred seventy-five feet, east of Sarah Morris Hospital for Children, a part of the Michael Reese group, with Twenty-ninth street on the north and Lake Park avenue on the east. The cooperation of the city council was secured to permit the construction of a bridge across Twenty-ninth street and the closing of an alley between Sarah Morris Hospital and the site for Meyer House. An L-shaped building was found to be the most adaptable to the needs. After much consideration eighteen beds was set as the minimum for an economical nursing unit. It was also determined that the maximum unit that was desirable for de luxe service was about twenty-eight.

The initial building, therefore, is planned for eighteen beds with service rooms somewhat larger than is necessary for that number, to permit of expansion to twenty-eight beds per unit should that be necessary. With the funds available and the size and plan of nursing unit determined, it



Service or private bathroom

was found that only a four-story building could be built. This decision was no doubt influenced by the fact that the adjoining building was but four stories in height. Funds available did not permit of the completion of the entire four floors of the building, consequently the first floor patients' rooms are unfinished. Future expansion, when necessary, will be southward, changing the present L-shaped building into a U-shaped one.

The planning of the typical floors determined the location of the visitors' elevator. This, in a general way, fixed the location of the main entrance. Fortunately this placed it on Twenty-ninth Street, the northerly front and the main automobile approach, and permitted the bridge to form a covered way to the entrance.

Throughout the design, the first impressions have been considered of paramount importance.

As most of the patients will arrive at the front door, this covered way will be a comfort on stormy days. Just inside the vestibule is a wheel chair closet, so that, if necessary, the patient may be wheeled through the lobby to the elevator.

On one side and opposite the entrance is the information desk and business office of this building. On either side of the vestibule are small reception rooms, attractively furnished, for waiting relatives and friends. The fireplace in the lobby is a real wood burning one and will add a cheerful note.

As this building is entirely dependent on the main administrative offices of the hospital, only such necessary offices are provided as that of supervisor of the building, bookkeeper and information clerk. Ambulance service is from the rear. Note the control of both front entrance and ambulance entrance from the administrative center. A convenience at the office center is the package closet for the temporary disposal of packages for patients, and there is a stretcher cart storeroom next to the ambulance entrance. Telephone booths and toilets are conveniently placed. While the main physicians' coat room is found in the main hospital, a small one is provided here for their convenience. The stair at the east end of the lobby leads up to the patients' section of the first floor and is about four feet six inches above the side-

walk. This may also be reached via the elevator.

Leaving the lobby, the patient or visitor enters the elevator, quite unlike the usual cab. Except for its size it might readily be mistaken for the elevator of a fine apartment house or hotel. A fan insures a comfortable circulation of air. Control of the elevator will be by operator during the day and evening hours, but after evening visiting hours, by push button control. The ventilation of this cab, apparently as tight as a drum except for the entrance door, is through louvers at the top and bottom of the cab. This type of ventilation has proved entirely satisfactory during the three months of operation. This, coupled with fascia plates, (strips of steel the width of the doors extending from door sill to head of door below) has permitted an economy both in building and operation. The shaft was left un-

plastered and unpainted. The saving in building costs is not great but one who has tried to keep elevator shafts clean will appreciate what it means in maintenance.

As the patient leaves the elevator, he enters a small vestibule or foyer with an information booth, from which he is conducted to his room.

The vaulted corridor is attractive, and because of the sound absorbing material with which the ceiling is covered is singularly quiet. This feature is appreciated by both patients and guests.

The rooms are furnished in early American maple furniture. Gay glazed chintz on the comfortable chairs, cheery chintz hangings, a gay bridge lamp and a handsome bedside reading lamp make a quiet, comfortable and pleasant atmosphere. It might be a room in the patient's own home except for the height of the bed. The bed has a box spring with an integral back rest. The box spring is constructed so that both top and bottom are easily removable for cleaning. A short trial of these beds in the older buildings clearly indicated the need for box springs in Meyer House.

After careful study it was agreed that twelve by fourteen feet was the minimum size for a room required to provide the kind of care to be given here. And this was determined by the simple means of building a room in skeleton and placing the furniture in it. This was well worth the time and study devoted to it, for as far as the patient is concerned, once he gets to his room, the rest of the hospital may be what it will provided he is comfortably housed and has appetizing food and prompt service. And then, too, it was hoped that there would be eighty of these patients' rooms, whereas there were but a few examples of any other unit in the hospital.

The first object was the comfort of the patient, the second, speedy, efficient service. Perhaps the second is really a part of the first.

By means of the study of the skeleton full-size model of the room, it was determined that (a) the average room area should be thirteen by sixteen feet; (b) the smallest should not be less than twelve by fourteen feet; (c) provision must be made for a three-foot bed, a bedside table, a chaise

longue or easy chair, two side chairs, a desk or writing table, an over-the-bed table and a closet.

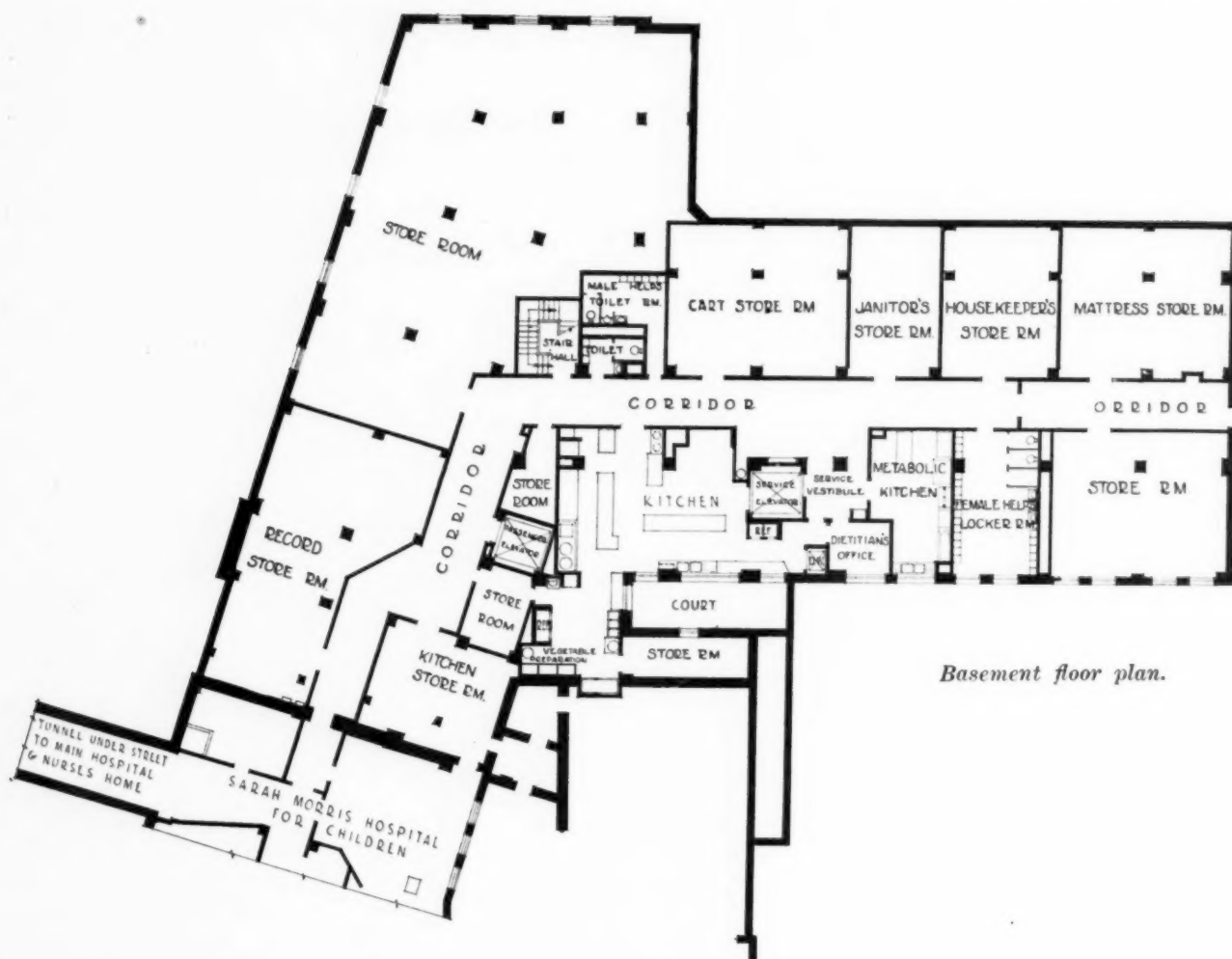
To allow the patient to move the easy chair and bridge lamp about the room and avoid excessively long light cords, extra plugs were placed about the room. Each of these outlets is of the duplex type, so that two pieces of electrical apparatus may be attached at a time. In all there are four duplex plugs in each room. Artificial illumination is by means of four attractive electric bracket lights, two on each side of the room. In addition to the brackets there is a simple form of night light about twenty-four inches above the floor, at the head end of the bed in its normal position. The brackets and night lights are controlled by separate tumbler switches. The nurses' call outlet is placed at a convenient height behind the bed. Ceiling fixtures are absent but a capped



A typical patient's room.

outlet has been installed, with a switch at the door.

Ventilation of the room is provided for in several ways. There is first the glass deflector at the double hung windows, and then a new type of door to the corridor. This door was first tried



experimentally at Michael Reese Hospital for about a year, and was found to be superior in every way to the familiar bar or half door. It will be seen that it functions both as a room door and, when both leaves are open, as an effective ventilator. So far it has demonstrated its value.

In addition there is an electric fan mounted in the outside wall of every room. The electric fan is a great comfort but it also is a great nuisance about the hospital. Hanging a fan on the wall is not new but the control of this one is interesting and probably new as used here. The fans are sixteen inches, oscillating with three speeds, but the rheostat that controls the speeds is not mounted on the fan, which is about eight feet six inches above the floor, but by a switch four feet six inches above the floor. This eliminates climbing on furniture to regulate the fan switch or the marring of walls from the ordinary pendant switch.

Each patient's room has its adjoining toilet or bathroom and these are miniature service rooms. Early in the study of the problem it was recognized that many rooms must have baths, not because they were of any great value to the patient but because he has become accustomed to a pri-

vate bath in connection with his bedroom. "Room and bath" are quite as commonly heard of in hospitals as in hotels.

The bath or nurse's service room was carefully studied to provide for every need of the nurse and doctor in caring for the patient. A spout was placed over the water-closet to make it effective as a bedpan sink. A marble-topped case provides a nurse's worktable. The case itself contains space for all of the nursing paraphernalia, such as hand and pus basins, ice bags and individual surgical dressing trays. An electric utility outlet is found directly over the worktable for procedures needing heat. The lavatory faucets are combined into one high one, and hot and cold water are controlled by single lever handles, enabling the nurse or physician to scrub up quite as effectively as in the operating department.

Adjoining the water-closet bedpan hopper there is a combination cabinet. The lower quarter is ventilated for the bedpan and urinal. The upper three-quarters is a space for the special nurse's clothes. Twenty-four hour nursing service is available and these nurses use the bathroom for a dressing room. For emergencies a nurse's call outlet is provided in the bath or toilet,

interconnected to the call outlet of the room itself.

The purpose of these necessary facilities is to make service to the patient speedier and more efficient, and they are placed close to the patients so that there is no need for the nurses to absent themselves from their patients.

The telephones in the bathrooms are an extension of the telephone at the patient's bedside. The latter, however, are only "jacks," and these phones are removable at will. The phone rings only in the bathroom, saving the patient the shock of loud bells directly under his ears. When nurses wish to give confidential reports to physicians or relatives they may do so undeterred by the presence of the patient, but at the same time without leaving the patient.

Each room has a small closet with shelf, electric light and hanging rod.

Experienced hotel men would say that this careful attention to the patient's room is all very well but what about "the back of the house," knowing full well that the success or failure of room service will depend on the "back of the house." And it is a rather interesting sidelight that the hospital world scarcely knows this expression. Few hospitals have a "back of the house." It's all out in front. The hotel man refers to kitchens, food service, housekeeping, mechanical and administrative services which the public rarely sees, as the "back of the house," in

contradistinction to the "front of the house," the rooms that the public sees and uses such as the lobbies, dining rooms and bedrooms.

The nurses' station is at the rear of the visitors' elevator. A visitors' reception room is provided for those friends who arrive at inopportune moments. Here there is a public telephone booth. The information clerk at the right of the elevator controls this room and with it the number of visitors to any patient. In the same room is the supervising nurse's desk, and the charting desks for pupil nurses and for doctors' and interns' use. A medicine cabinet of the usual type is provided. Adjoining this room is a special nurses' room, a room for the homeless private duty nurse whose patient has visitors. This room has a pilot light of the nurses' call system, so that the patient may call the nurse. Adjacent is a nurses' toilet. The ceiling of the charting room is of sound absorbing material.

Back of the nurses' station and connecting it to the service lobby and elevator is a long supply closet for linens, blankets and all miscellaneous supplies. These are dispensed by the supervising nurse or floor clerk, through the door at the station. They are received through the door at the service vestibule (without entering the corridor) from the S. O. S., the "service of supply."

This service vestibule functions in many ways. First, it is a vestibule for the service elevator;



Typical floor plan.

second it provides a convenient momentary depository for incoming or outgoing freight; third, it acts as a buffer for noises from the flower room and the clean and dirty utility rooms.

The clean and dirty utility rooms are in themselves interesting departures from the stereotyped plan. As bedpan cleansing and much similar work will be done in the individual service rooms the "dirty" utility room is of considerably less importance than in other hospitals. An enema can case of special design, a marble top worktable and cabinet complete its equipment. No bedpan or utensil sterilizers are installed. These utensils are sterilized in a central autoclave

Adjoining these rooms is the serving pantry. It has both dumb-waiter and elevator access to the kitchens directly below. Double "in" and "out" doors to the corridor will prevent many accidents and will eliminate noise in the corridor. The pantry may be divided into two parts, the portion nearest the door being for specials with its own range and supply case, and the space nearest the elevator for the pupil dietitians. Between the two are placed those things that are common to both—refrigerator and sink. The ceiling of this pantry, the most prolific source of noise in the hospital, is of sound absorbing material. One section of the refrigerator (mechani-



Visitors' waiting room.

in the main building when the patient leaves and the room equipment is changed. In this room the coarser and dirtier work which cannot readily be done in the individual service rooms is done.

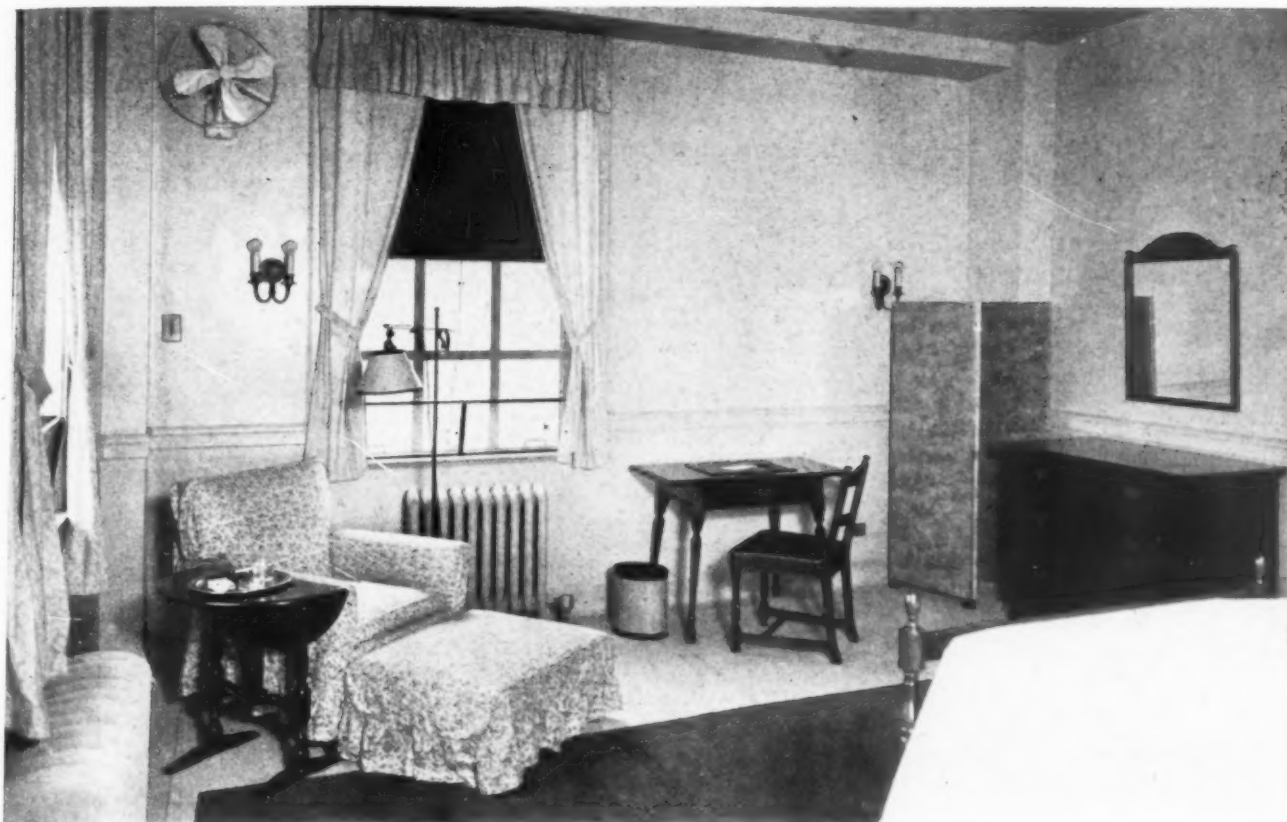
The "clean" utility room is surgically clean. Its equipment consists of an instrument boiler, a concealed water sterilizer, a blanket warmer, with heated saline cabinet, over a sink and drain board, and one large case, two sections devoted to sterile supplies and one section as an "exchange" case.

The flower room and the monel metal clothes chute, both open from the service vestibule.

cally cooled from the central plant) is divided into a series of woven wire compartments with padlocks, for the patients' own delicacies.

The food service is unusually interesting and so far has been successful. Soup and salads are sent up by dumb-waiter. The former is placed over the open flame, the latter in the ice box. The meats and vegetables are served by the chef in the kitchen and are sent up in individual plates and covered containers in a special, electrically heated food truck. This truck allows food to be served hot whenever the patient wants it. A

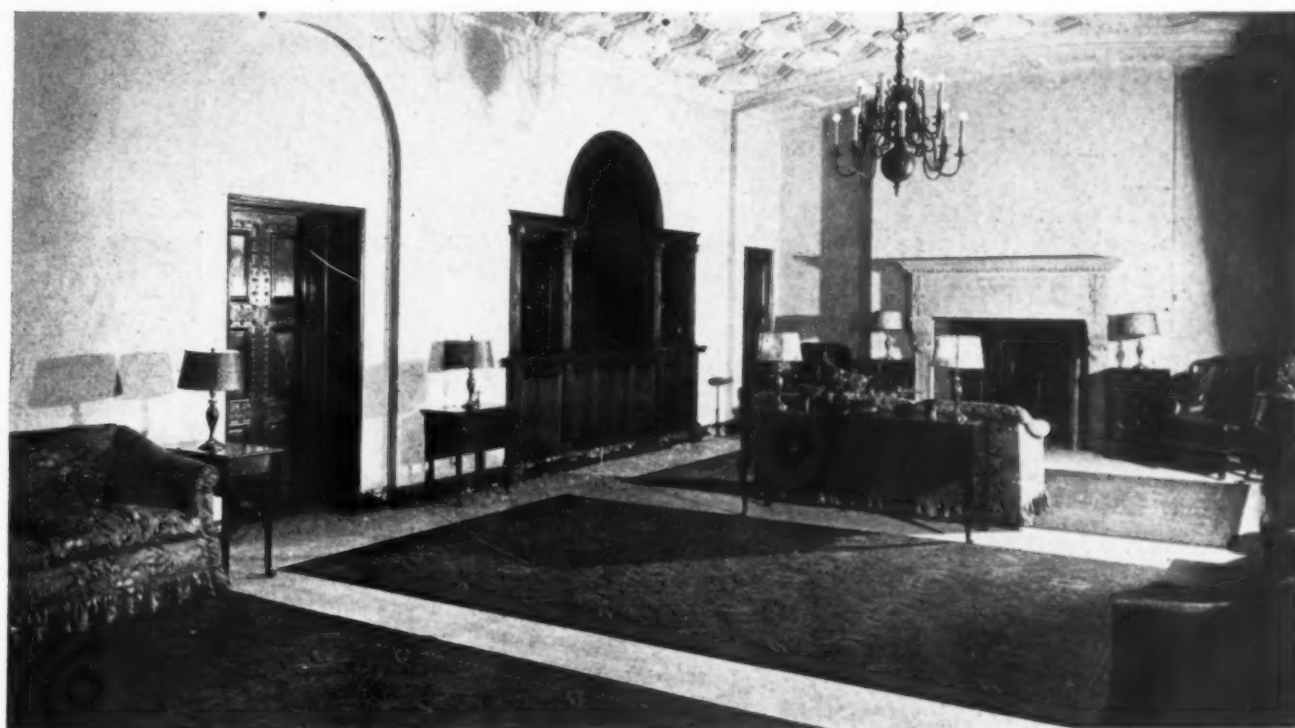
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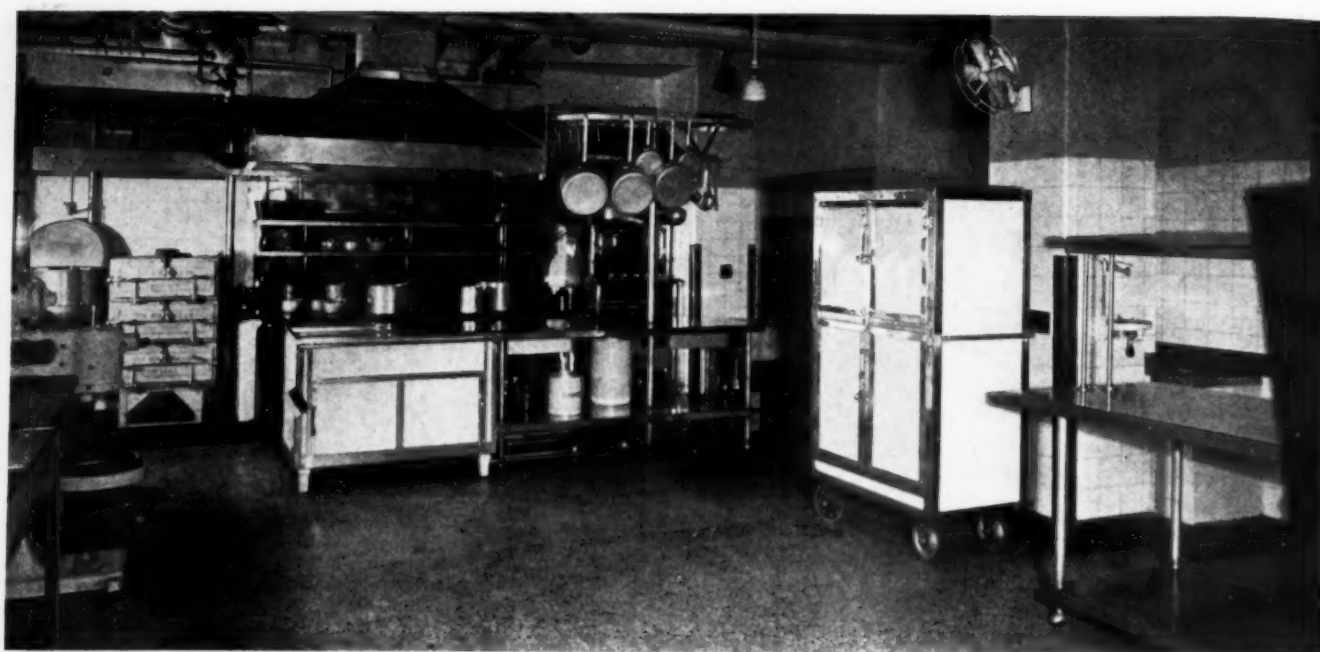
Gay glazed chintz and comfortable chairs feature this cheerful patient's room.

delay of five minutes or twenty-five minutes does not affect the food. Food is served in two and sometimes three courses, first soup and then meat, vegetables, salad and dessert, unless the latter happens to be ice cream when it makes a third course. In the meantime those who like coffee are

served from individual electric coffee percolators, prepared in the serving pantry and only needing water and connection to the room electric outlet. This permits of coffee of any strength or quality. Nourishments, such as orange juice and malted milk, are sent up from the kitchen on order.



The lobby is luxuriously furnished with upholstered furniture and handsome rugs.



The kitchen. An electrically heated conveyor is seen at the right.

The general service kitchen, dietitian's office and metabolism kitchen are conveniently grouped around the service elevator and dumb-waiter in the basement. These present no radical departures from the principles of any well planned kitchen. Food storerooms and refrigerators are limited for all classes of food supply and are issued from the main hospital storerooms on daily requisition. A chef is employed under the direction of the dietitian.

Food carts are preheated in the kitchen before being sent to the floor pantries. Dishes will be washed on the floor pantries. Provision is made for a central dishwashing room in the basement, if this should become necessary when the hospital grows to its ultimate capacity of 128 patients.

Although the present administration believes the method of food service outlined above is the one best adapted to present needs, the building is planned so that food may be served by complete tray service from the main kitchen to the pantries or by reheating bulk food in the pantries.

The basement contains locker rooms for help employed in this building, a main janitor's cleaning gear room. But by far the greater part is used for storerooms.

The basement connects directly with Sarah Morris Hospital and thence, via tunnel, to the main hospital and nurses' home. At the south end it connects with the temporary intern's quarters.

The third floor of Meyer House connects by the bridge across Twenty-ninth Street to the second floor of the main hospital building where a new surgical building is under construction. Through

the remodeling of a portion of this floor the x-ray, metabolism, cardiograph, physiotherapy and dental departments will be located so that they will be equally accessible to the main building, children's building and private patients' building. The fourth floor of Meyer House connects with the third floor of the main building where are the birth rooms. This permits Meyer House to be used for all kinds of patients.

A separate private patients' building always brings up a host of questions. How far must it be independent of the therapeutic and diagnostic services of the main hospital? Should it be dependent on the main hospital for x-ray? For physiotherapy? For operating departments? Every known form of compromise is effected, but it is generally agreed that a single service in these facilities is desirable when possible.

Unfortunately there are usually great physical difficulties in the way of this goal. In this instance, had it not been for the generous action of the Chicago City Council which permitted bridging Twenty-ninth Street, it would undoubtedly have been desirable to provide a separate operating department for Meyer House and the adjoining children's department.

A few details not mentioned deserve some comment. The occasional psychiatric, burn or dermatological case is provided for in a continuous bath room off one of the rooms on the second floor adjacent to the bridge.

Reference has already been made to wheel chair and stretcher storage room at the entrances. A wheel chair is provided on each floor, as well as a wheel stretcher closet.

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Each floor has its open air balcony at the end of the corridor. The first floor, when completed, will have a series of balconies outside of the south and east rooms and overlooking the garden. A fence encloses it. This garden is reached from the first floor by a ramp, which will permit the patients in wheel chairs to reach the garden. The absence of roof gardens and solariums is deliberate. Had more money been available they would undoubtedly have been added. It was decided after careful deliberation that they were not necessary for this class of patient.

Provision is made for suites in the northeast wing. These are arranged for either one, two, three or four rooms as may be needed. Rare indeed is the patient who requires more than two rooms, and this added facility is accidental rather than purposeful. The primary purpose is to permit of flexibility, if one room is not available to join up with the patient's room, the other may be.

Floors Are of Terrazzo

All floors, except a six foot strip in the corridors, are of terrazzo, and special consideration was given to the cleaning gear. As scrubbing trucks had been long since adopted throughout the institution, it was determined to design the janitors' closet to fit this new form of equipment instead of attempting to make the older form of slop sink do this job. The result is a new form of slop sink and janitor's closet. A separate place is provided for the mop truck. The slop sink itself is formed of terrazzo with a curb at its outer edge, just high enough so that the truck drain may pass over it. The side walls are wainscoted in terrazzo. The slop basins are purposely large. Hooks are provided on the walls so that mops may hang up to drain and dry. These new janitors' closets have proved satisfactory. An improvement might be to place the combination faucet on the side instead of the back of the basin and then make it a swinging spout. This is open to some objection but it would make it easier to fill the mop trucks.

Screens are of metal with a solid bronze bottom rail and copper bronze wire. It is planned to leave these up the year round. The bronze bottom rail will not rust. It is expected that the additional expense will be more than offset by the saving in handling and wear and tear, caused by removing and hanging the screens each year.

Special precautions have been taken with the ventilation. As far as patients' rooms are concerned, primary dependence is placed on natural ventilation. Each room has two large windows. Each is equipped with an extra deep bottom rail to permit ventilation, via the check rail. In ad-

dition glass deflectors are provided for every sash. The doors to the corridor have no transoms but have the ventilating panels previously described. Exhaust ventilation takes care of the private baths and toilets, through the bedpan compartment. Incidentally two of these compartments are generally back to back and the problem of avoiding transfer of noises from one bath to the other was successfully solved.

Exhaust ventilation is also provided for all pantries and utility rooms and for the kitchen. This should keep the patients' rooms and all corridors and visitors' spaces free from odors. To make insurance doubly sure, however, fresh air is blown into the corridors. As there is a slight vacuum on the odor producing areas this slight plenum in the corridors should keep them untainted. Fresh air is also supplied to the kitchen and to the lobby, in order to avoid opening windows and inviting in the dust-laden air, increasing housekeeping and maintenance costs.

On the second floor the orderly is housed and signals are arranged to call him to either of the first three floors.

Completely furnished, but without the bridge, the building cost about \$567,000. There are fifty-three rooms but sixteen more rooms can be added on the first floor at a cost of about \$50,000. This would make a total cost of \$617,000 for sixty-nine rooms, or about \$9,000 per room.

Interior Decorating a Feature

The building with all its mechanical details for the comfort and care of the patient would be only a building, except for the taste and common sense of the decorators. The interior decorating was done by Samuel A. Marx, with the active cooperation of Mrs. Carl Meyer and Mrs. Arthur Spiegel, the furnishing committee of the women's board. To these and other members of the woman's board who assisted in selecting the furnishings the hospital's thanks are extended.

We wish to make grateful acknowledgment of the continued and enthusiastic help of our associates in the architect's office and in the hospital through the trying and often discouraging process of working out and changing the multitudinous detail.

To Edwin Meyer, spokesman for the Meyer family, we wish to extend our thanks for the opportunity to work out for them and the community our conception of an ideal private patient's building.

The test of every building is time, and it is too soon to evaluate all the details. It may be said, however, that so far they are proving their value and measuring up to expectations.

WHAT CONSTITUTES A CLASS "A" HOSPITAL?

By Malcolm T. MacEachern, M.D., C.M., D.Sc., Associate Director, American College of Surgeons and Director of Hospital Activities,
Chicago

IN THE present day we speak freely of the so-called Class A hospital, whereas, in reality, there is no such national or international designation. The American College of Surgeons has up to the present refrained from adopting an A, B, C classification of hospitals inasmuch as it is difficult to differentiate in this manner without gradings within each group. It is found that some hospitals are "super" in type, others basic or fundamental, while others range from this down to the so-called "rooming" or boarding house type.

As a practical solution of grading of hospitals has not yet been reached, therefore, the American College of Surgeons in its work of hospital standardization differentiates hospitals into three groups, namely: Fully approved, conditionally approved and not approved; based on the degree to which the hospital in question is meeting the minimum standard requirements, which are as follows:

What A. C. of S. Requires

1. That physicians and surgeons privileged to practice in the hospital be organized as a definite group or staff. Such organization has nothing to do with the question as to whether the hospital is "open" or "closed," nor need it affect the various existing types of staff organization. The word staff is here defined as the group of doctors who practice in the hospital inclusive of all groups such as the "regular staff," the "visiting staff," and the "associate staff."

2. That members upon the staff be restricted to physicians and surgeons who are (a) full graduates of medicine in good standing and legally licensed to practice in their respective states or provinces; (b) competent in their respective fields and (c) worthy in character and in matters of professional ethics; that in this latter connection the practice of the division of fees, under any guise whatever, be prohibited.

3. That the staff initiate and, with the approval of the governing board of the hospital, adopt rules, regulations, and policies governing the professional work of the hospital; that these rules, regulations and policies specifically provide: (a) That staff meetings be held at least once each month. (In large hospitals the departments may choose to meet separately.) (b) That the staff review and analyze at regular intervals their clinical experience in the various departments of the

hospital, such as medicine, surgery, obstetrics, and the other specialties; the clinical records of patients, free and pay, to be the basis for such review and analyses.

4. That accurate and complete records be written for all patients and filed in an accessible manner in the hospital—a complete case record being one which includes identification data; complaint; personal and family history; history of present illness; physical examination; special examinations, such as consultations, clinical laboratory, x-ray and other examinations; provisional or working diagnosis; medical or surgical treatment; gross and microscopical pathological findings; progress notes; final diagnosis; condition on discharge; follow-up and, in case of death, autopsy findings.

5. That diagnostic and therapeutic facilities under competent supervision be available for the study, diagnosis and treatment of patients, these to include, at least (a) a clinical laboratory providing chemical, bacteriological, serological and pathological services; (b) an x-ray department providing radiographic and fluoroscopic services.

Some institutions, however, interpret the above classification of grading as Class A, B and C respectively, which is not entirely correct. The time, I believe, is close at hand when a proper classification or differentiation may be expected. In the meantime the great task to be accomplished through the hospital standardization movement is to raise every institution up to the minimum requirements at least.

Essentials for Class A Hospital

The essential requirements for what might be designated a Class A hospital are far-reaching and impossible to be described in detail within the scope of this paper. They may be considered under the following general headings: (a) Functions; (b) Planning and Construction; (c) Furnishings and Equipment; (d) Administration; (e) Procedures. This, as you see, is a large order, and I must, therefore, limit my remarks chiefly to basic principles or considerations, the details of which can be interpreted and worked out to the individual setting and needs of each institution.

Regarding a Class A hospital as the most highly developed type of such institution, we naturally expect the exercise of its broadest function or

purposes in the community. It should, therefore, be prepared efficiently to carry on four fundamental functions generally ascribed to such institutions. These are:

1. The care of the sick. I should like to qualify this to read: "The right care of the sick." No one will dispute the fact that the care of the patient is always the primary object of every worthy hospital. The hospital is primarily for the patient, where the tried and accepted accumulative knowledge and skill of physicians, nurses, laboratory workers, and others, are at the disposal of the patient to be applied scientifically and sympathetically in order that the patient may receive the maximum benefit. A hospital of this kind should constantly focus all its energies, interests, and activities on the best care of the patient that can be rendered both custodially and scientifically. To this end every man, woman and child, regardless of race, color, creed or social status, must be given the best that scientific medicine can offer.

What Hospital Should Offer

This presupposes such an environment in the hospital as will afford (a) an early, accurate diagnosis; (b) the application of the best methods of treatment known to scientific medicine; (c) the return to health if at all possible in the shortest time and most comfortable manner; (d) adequate follow-up so as to assure the best end results. This is the curative function and responsibility of the hospital.

2. The education and training of doctors, nurses, dietitians, social workers, technicians and others required for the various activities in the hospital field. This is accomplished through systematic instruction and demonstrations, in addition to well supervised extensive apprenticeship and routine experience.

Here the practicing physician particularly should have ample daily opportunity to improve his scientific knowledge through continuous post-graduate experience afforded by the hospital. The intern fresh from college and perhaps with a superabundance of theoretical knowledge, has ample opportunity to round out and balance his medical education through carefully directed practical experience. The student nurse receives carefully supervised theoretical and practical instruction in accordance with the best standard curriculum of study. The dietitian, the social worker and other persons filling essential posts in the organization constantly advance their knowledge through practical experience supplemented by courses of instruction as may be required. It is an accepted principle that the more a hospital teaches, trains, and educates,

the better service it can render the patient. The educational aspect of the hospital should therefore be developed to the highest degree.

3. The prevention of disease. A Class A hospital is expected to play an important role in the health program of the community. Through its organization, personnel, facilities and activities it must disseminate a continuous influence throughout the community for better health and welfare conditions. Not only should the hospital educate the community to the full appreciation of scientific medicine and the adequate care of the sick, but it should seize every opportunity to foster and encourage more interest in personal and public health matters. The hospital holds a strategic position for the promotion of health and betterment of general welfare conditions in its own community and the nation at large. Preventive and curative medicine are inseparable and should be carried on side by side in the hospital.

4. The advancement of scientific medicine and research. A Class A hospital with its organization, trained personnel, laboratories, clinical departments and assembled data, should seize every opportunity to promote scientific medicine—curative, preventive and research. Present day medical knowledge is by no means complete or stationary; it is constantly changing. The keen and alert doctor finds it necessary constantly to augment, adjust or replace scientific knowledge in his mind. A Class A hospital can be the best laboratory for the promotion of clinical research through the discovery, study, and application at the bedside of new knowledge pertaining to diagnosis and treatment. Without the earnest co-operation of hospitals scientific medical research will be retarded.

Development of Research

Probably one of the most outstanding features in this respect is the work of the committee of the American College of Surgeons on bone sarcoma, which has studied between seven and eight hundred cases of this nature during the past five years in the United States and Canada. The findings of this extensive investigation have been recently summarized in a magnificent monograph by Dr. Anatole Kolodny, which is now a valuable and reliable textbook on this subject. The interesting part of the entire undertaking was the number of hospitals participating in this particular piece of research. I know of no other field offering more opportunity today for clinical research than the Class A hospital.

In the consideration of what constitutes a Class A hospital, location and site cannot be overlooked. There are numerous factors in this connection

bearing directly and indirectly on the care of the patient. Sufficient attention has not been given to this matter in the past. The subject is worthy of mention and consideration and the following requirements are laid down:

1. Accessibility to transportation and communication lines. The need of this is self-evident, when one realizes the intimate contact that is essential at all times between the hospital, the patient, the physician and the public, as well as the necessity for meeting the institution's physical needs.

2. Adequate area for present and future needs and landscaping of grounds round and about the institution, as well as preventing undesirable buildings or conditions in close proximity. Experience has definitely proved that almost every hospital needs expansion every ten or fifteen years on the average. The time to provide for this is when the building is being planned. The prevention of undesirable neighbors can most safely be accomplished through having as much ground as possible around the institution. It is also desirable to make the surroundings as attractive as possible through landscaping.

3. Proper elevation for good drainage and general sanitary measures. This is a universal principle that should apply to all institutions where people are congregated, particularly in large numbers. It is self-evident that such a consideration applies particularly to a hospital.

4. Freedom from nuisances such as noise, smoke and odors. The reaction of the patient to such conditions is generally found to be somewhat sensitive, and these features should be eliminated if the welfare of the patient is given the best consideration.

5. Elimination or adequate protection from physical hazards such as precipices, forests, bodies of water, dangerous occupations or industries. It may be difficult to secure a location where there are not some such hazards. Realizing that the hospital is in effect the official guardian of the patient, protection against hazards of this kind is essential. Not infrequently patients take advantage of such hazards to terminate life. Attention to this particular phase is essential for the physical safety of the patient.

6. Adequate provision for maximum air and light to all parts of the building. Air and light are important factors in the treatment of every patient and cannot be placed in the background. In addition, we must also consider the health of the workers in the institution. Light and air in maximum quantities can be had at no expense to the hospital and should therefore be liberally supplied.

7. An environment conducive to the comfort of the patient. The physical reaction of the patient to his surroundings should be such as will be conducive to his pleasure and comfort. Undoubtedly, being able to see with ease beautiful scenery round about is an advantageous factor in the patient's convalescence and recovery. Nature plays her part in the treatment of disease, and we should always give her a chance.

The increasing importance placed on the matter of location and site is encouraging. The above factors should never be overlooked when a new hospital is projected. These are reasonable requirements, inasmuch as it is well known that environment has much influence on the patient—physically and psychically, noticeably affecting the manner in which treatment is taken, as well as having a direct bearing on the ultimate results obtained.

Principles of Planning

Hospital planning and construction today is a specialty of no little importance, because of its bearing on service to the patient and maintenance cost. There are a few outstanding principles particularly applicable in a Class A hospital, and the following are submitted for consideration:

1. Providing for the safety of the patient through fireproof construction, and the elimination of hazards within and without the building. It is essential that hospitals be fireproof for the safety of the patient, particularly when it was stated a few years ago that one hospital a day, on the average, is burned in the United States, sometimes accompanied by loss of life. It is gratifying to note that the various states are putting into effect strict regulations in this regard. In the present day it is rare to find an institution being erected which is not almost wholly fireproof. Furthermore, a Class A hospital to be worthy of the designation, must be safe physically for its patients.

2. Providing for the physical and mental comfort of the patient. We cannot overlook the physical and mental comfort of the patient. This can be provided for through active, homelike appointments, pleasingly tinted walls, sitting rooms, sun parlors and roof gardens, when practical. It is desirable to put the institutional aspect of the hospital in the background as far as possible. The tendency now is to make the hospital more and more like the home.

3. Proper planning and correlating of the administrative, service and scientific units or departments. A hospital, physically and functionally, is made up of numerous units which must be properly planned and correlated in order to run

with maximum efficiency and economy. These various units are so intimately associated with each other as to make them more or less interdependent. Each patient simultaneously shares part of the administrative, service and scientific units. All three are essential for the care of the patient and should be arranged physically so as to promote the smooth running of the entire institution, to economize on time and labor and to get the service to the patient quickly. Therefore in the physical set-up of the institution the definite correlation of these units should be carefully worked up, focusing particularly on the above three advantages.

4. Ample provision for proper housing of the nursing staff and other personnel of the hospital. Not infrequently hospitals are built without due consideration of caring for the personnel. If good service is expected from the personnel good living conditions must be provided. It is therefore vitally important, simultaneously with the construction of the institution, that provision be made for the various groups concerned with the carrying on of the work of the hospital.

A Class A hospital must make adequate provision for general furnishings and equipment most conducive to the physical comfort and scientific welfare of the patient. These two conditions go hand in hand. Modern general furnishings for hospitals are readily available and fairly well standardized. Each unit in the institution requires its proper quota, but not to the extent in which it might in any way interfere with the use of scientific facilities as required in the diagnosis and treatment of the patient. It is important to eliminate discomfort to the patient so far as the furnishings are contributory to this condition.

Perhaps in the past hospitals have failed to pay sufficient attention to the providing of attractive and pleasant surroundings for the patient.

Two Classes of Equipment

Equipment is generally regarded as the mechanical apparatus and appliances required in the care and scientific treatment of the patient. This has also been standardized, but to a lesser degree than the general furnishings. Equipment is divided into two classes: general and special or scientific. It is so vitally important that hospitals give careful consideration to the question of general furnishings and equipment that I submit the following recommendations for a Class A hospital:

1. That there should be adequate and suitable general furnishings and equipment most conducive to the physical comfort and scientific welfare of the patient. The furnishing and equipping of

each hospital is an individual consideration. There should be sufficient of the proper kind of furnishings and equipment for the various units of the institution. As hospitals vary so much in their principles, planning and construction, a definite specification should be laid down in each individual case, keeping in mind always the physical care and the scientific welfare of the patient.

2. That modern and standardized furnishings and equipment, so far as possible and practicable, be provided. Considerable work has already been done by the American Hospital Association and the division of simplified practice of the U. S. Department of Commerce, Washington, D. C., and other bodies to standardize hospital furnishings and equipment, particularly the former. Such standardized equipment is now on the market and should in all cases be considered primarily when furnishing and equipping the hospital. This will mean greater efficiency and economy.

Maintenance Service Necessary

3. That all furnishings and equipment be readily available and in good condition for use at any moment. An organized service for the keeping of furnishings and equipment in good condition is an essential factor in every hospital. Wear and tear in a hospital is always considerable, and a constant maintenance service should be readily available so as to keep all furnishings and equipment in such a condition as to be ready for use at any time.

4. That scientific equipment be carefully selected according to definite specifications or standards, and placed under the supervision and operation of persons qualified for that purpose. The extensive variety of scientific equipment available at present makes it imperative to select such equipment carefully and in accordance with intelligent specifications or standards setting forth type, uses, qualities and quantities. These are basic considerations, which must be well thought out in each individual instance. Scientific equipment is costly, complicated and delicate. It is therefore advisable that supervision and operation be delegated only to those properly qualified for that purpose. The common use or operation of scientific equipment by everybody in the hospital is not only damaging, but dangerous to the operator and the patient. This should be strictly prohibited.

Hospital administration is now regarded as an art or science requiring native executive ability, administrative and technical knowledge, an anticipating and judicial mind, a personality clothed with industry, tact, kindness, sympathy and other human characteristics and other special qualifica-

tions that cannot be mentioned here. Year after year the hospital is becoming more and more intricate and complicated in its functioning, and thus increasingly difficult to administer. It has within, numerous and various departments, activities, and relations, not to say anything of its many responsibilities to the community. All this is forever increasing, so that today hospital administration, like other professions, must be placed on an academic basis in order better to equip the incumbent for this important work. A move in this direction has already been made in some places.

A hospital may be an attractive and complete physical plant with the finest equipment that money can purchase, but unless it is properly administered all may be for naught insofar as its service to the patient and the community is concerned. The physical and scientific facilities must be brought into proper focus and alignment and intelligently guided for the rendering of efficient service to the patient. This is the most important consideration in a Class A hospital.

Efficient hospital administration presupposes a square deal for every patient treated in the institution. That should be the common basis of all hospital interests and activities. And we should be thankful that this condition prevails generally throughout the hospitals of America. The administrators of American hospitals are serious in their task, and doing noble and efficient work. This is particularly borne out by the fact that the increase in approved hospitals, as recorded by the American College of Surgeons, is approximately two thousand per cent in the past ten years. Further evidence of even a more convincing nature is found in the improved hospital results—the shortening of the average days' stay of patients, the lowering of hospital death rates, the reduction in complications and infections and the general improvement in end results, as statistics indicate.

Administrative Requirements

An analysis of the art of hospital administration based on personal experience and long investigation and thought warrants me in laying down six fundamental requirements for hospital administration that should characterize a Class A institution. These are:

A. Organization. A Class A hospital requires definite, clear-cut organization, setting forth duties, relations and responsibilities for all groups and individuals in the institution. This is essential for the efficient smooth running of the hospital and the best interests of service to the patient. While comprehensive organization is essential in

all successful undertakings—commercial, educational, professional or other, there is no place where it is more necessary than in the hospital—an institution constantly dealing with life and death and where the watchword must always be preparedness. All this should be expressed in a well arranged, acceptable constitution, by-laws, rules and regulations, carefully compiled and distributed throughout the organization so that each person connected therewith can be thoroughly familiar with them. The following fundamental principles are set forth for proper organization in a Class A hospital:

How to Organize

1. That the supreme authority and full responsibility for the entire institution be vested in a definitely named governing body composed of trustees, directors, commissioners or other designated bodies. Membership on the governing body of a Class A hospital should be limited to such persons as have the time to devote to this work, are interested, philanthropically inclined and thoroughly imbued with a real community spirit. Their talents should be diversified and such as can be used to the advantage of the hospital through more ready adaptation of any member to the particular task assigned. The membership of a group of this kind should not exceed twelve to fifteen, although six to nine is generally considered desirable.

2. That the governing body be charged with the responsibility of the formulation, adoption, and carrying out of administrative, professional, educational, and other policies concerning the hospital. It is taken for granted that in this matter the governing body must have full knowledge of the situation, and seek the advice of the superintendent, medical staff, and other individuals or groups immediately concerned.

3. That the governing body delegate the authority and responsibility for carrying out policy to a competent chief executive officer or superintendent. The chief executive officer or superintendent must be supreme within the range of policies vested in this office by the governing body. If this is not the case it is difficult to run the hospital smoothly or efficiently. There can be only one executive officer or head in a well regulated institution.

4. That the superintendent or chief executive officer organize the work into major divisions, such as medical, nursing and business, each under the direction of a capable officer: (a) a medical superintendent for the medical department: (b) a director of nursing for the nursing department: (c) a business manager for the business depart-

ment. All hospital activities can be included under the above three main divisions. The heads of these divisions may act as assistants or first lieutenants to the superintendent or chief executive officer.

5. That the three main divisions as stated above be laid out into units or departments, each with the necessary competent personnel under proper supervision. When the organization is complete the departmental staff will be responsible to the department head; the department head in turn will answer to the divisional officer, who is accountable to the superintendent or chief executive officer representing the governing body in the carrying out of policy and the general administration of the hospital. A comprehensive chart of organization should be displayed in the hospital in a prominent place.

Medical Staff Needs

The organization of the medical division of the hospital is necessary for administrative and clinical purposes in the efficient functioning of the institution. Good medical staff organization presupposes:

a. The careful extension of privileges to doctors to practice in the hospital. This should be taken up in three stages, as recommended by the American College of Surgeons—application, credentializing and appointment or rejection. The doctor makes application in accordance with a prescribed form setting forth qualifications for the privilege of practicing in the hospital and becoming a member of the general staff. This information, when complete, goes before a credentials committee of the staff, which expresses its opinions or recommendations to the governing body. It is the function of the governing body to act finally and make all appointments of this kind. The appointment of members to the staff should be done according to appropriate standards for the respective positions to be filled.

b. The appointment of the various officers such as chairman, vice-chairman, secretary, and special committees. This organization of the staff is mainly for administrative purposes but is also necessary for the proper conduct of the staff conference.

c. The departmentalization or differentiation of the medical staff for clinical purposes. Following are the divisions or departments, with a head for each, which are recommended: surgery, medicine, gynecology and obstetrics, ophthalmology, otolaryngology, rhinology, urology, orthopedics, pediatrics, neurology, psychiatry, pathology, radiology, anesthesia and other specialties and sub-specialties as deemed advisable. The head of

each department should be responsible for all the work therein. Through this means the clinical work of the hospital can be more efficiently carried out. In the set-up it must not be forgotten that a contact or liaison should be maintained between the medical staff and the governing body. It is most desirable to have a committee from the governing body or executive. This forms the best link or communication between the governing body and the medical staff, in addition to that of the superintendent or chief executive officer.

The nursing division or department must also be well organized to carry out its dual function—the care of the patient and the education of the student nurse. This presupposes: (1) A department of nursing under a competent superintendent or director of nursing with an adequate staff of assistants for general administration and teaching purposes; (2) competent graduate nurse supervision over the wards and departments, such as operating room, maternity, out-patient; (3) an adequate corps of nurses and adjunct staff for general and special duty to care for the patients in the hospital efficiently. It is vitally important that this department be well organized in the manner described, as the nursing service plays such an important role in the care of the patient. Further, the care of the patient and the education of the student nurse can be carried on simultaneously in a more efficient manner if the department is well organized.

Competent Business Manager Needed

Likewise, it is essential that the business division of the hospital be well organized with a competent business manager in charge, responsible to the superintendent, and the work departmentalized according to the various activities such as purchasing, accounting, collections and secretarial. This division should also be responsible for the physical aspect of the institution in seeing that it is always in good condition for the immediate and efficient care of the patient.

Efficient organization throughout the hospital, with competent administration, assures good service to the patient, which must be the uppermost desire of all connected with a Class A institution. Organization, made up of a number of units as described above, is no stronger than its weakest link, and therefore it behooves those in authority to see that each unit or department is up to full strength. The superintendent must always know when he is receiving proper service from each department. He may not know the actual technique of the department but he must be able to judge the quality of the product. An efficient and responsible organization will be such that a compe-

tent chief executive officer can readily place his finger on the trouble or weakness and immediately know what remedy to apply. It is therefore essential that those in authority give the closest attention to the matter of organization. While the outline described herein may apply in detail more particularly to the larger hospitals, yet the same principles can be applied and adopted in smaller institutions in a modified manner.

B. Coordination. The second fundamental principle that should characterize the administration of a Class A hospital is that of coordination. In a hospital we have a large number of units contributing to the service, each performing a particular function. A study of the working of the hospital reveals a marked interdependence among the various units or departments. They must therefore be well coordinated or fitted together in their functioning in order to prevent overlapping, duplication or omission, with consequent wastage of time, energy and money. Without proper working relations and necessary adjustments among the various units or departments the organization is apt to lose some of its momentum and effectiveness. This is a feature, therefore, that should have careful attention in order to ensure good service.

C. Cooperation. Lack of cooperation within the hospital is a destructive factor in efficient administration and progress. Internal discord is ruinous, weakens effective action and reacts detrimentally upon the whole institution. There should be the finest spirit of cooperation within each department and among the various departments that make up the entire organization. Cooperation provides a smooth-working organization. Its effect can be detected even on entering the hospital and permeates the entire institution from the front to the back door, from the basement to the garret, resulting ultimately in the best care of the patient and the fulfillment of all the functions previously mentioned. It costs nothing, it pays the biggest dividends, and is the best antidote for inefficient service. Unless the entire organization acts in unison as one harmonious family, one hundred per cent efficiency cannot be assured.

Lack of Cooperation Is Infectious

A superintendent who knows and practices the art of good administration cannot fail to detect the non-cooperative individual or unit and deal therewith expeditiously. No time should be lost in applying the remedy, for lack of cooperation is frequently infectious and spreads rapidly. A good stimulus to promote cooperation in any institution is the round table conference of executive officers, supervisors and heads of departments held at fre-

quent intervals to discuss administrative problems of mutual concern, appraise the service, and promote ways and means of increasing efficiency. Such a conference will tend to consolidate the varied interests into a smooth-working whole.

D. Efficiency. A Class A hospital must always aim at a maximum degree of efficiency. This presupposes efficient organization, modernly planned and equipped physical plant, adequate diagnostic and therapeutic facilities and trained personnel under competent supervision. There must be an intensive focusing of interest, attention, and activities of all concerned on the patient, and the entire personnel must be imbued with the consciousness of the importance of their individual tasks, realizing that each is contributing a unit of service in the care of the patient.

What the Patient Is Entitled to

Every patient on entering the hospital should be assured of an early, accurate diagnosis, modern, scientific treatment and the return to health—if at all possible—in the shortest time and most comfortable manner. This is what the patient expects, has the right to demand and should receive if the institution is functioning efficiently.

Efficiency is best measured by the study of end results. This can best be done through a periodic analysis of the functioning of all departments of the institution, always keeping in mind that service to the patient counts most in any appraisal. Low average days' stay of patients, low hospital death rate, infrequency of infections and complications, are a few of the favorable indices of efficiency.

E. Service. The fifth important principle applicable to a Class A hospital is that of service. This is the basis of all worthy enterprise. It is the principle upon which a hospital should operate. All the personnel, individually and collectively, must focus their entire attention and best efforts on the patient—the common perspective or objective for all activities of the hospital. Service must ever be the watchword. The crucial test of service rendered is the turning out of a good product. The patient is the product of the hospital and its service. Is the administration putting forth every effort to provide the patient with one hundred per cent service from every department in the hospital? Has the diagnosis, the treatment or the convalescence been retarded through lack of good care, proper facilities, competent personnel or anything else?

Service is what counts today, and upon this only is a hospital justified in existing and expecting support. In no other institution is it so essential as in the hospital, where life and death hang

constantly in the balance. It should never be superseded by commercialism, politics, selfishness or other influences detrimental to the patient's best welfare.

F. Economy. The last important fundamental principle that should apply to a Class A hospital is that of economy. Wastage of time, energy or money in a hospital is unnecessary and fore-shadows inefficient management. Economy with efficiency is always desirable. As efficient administration will take full cognizance of this important factor.

There are many ways of promoting economy in hospitals. A few of these are worthy of mention at this time and are: (a) the systematic planning of work daily; (b) the regular, competent inspection of all departments to detect sources of wastage of any kind; (c) the careful accounting for every article as to where it comes from and where it goes to eventually; (d) the providing of a budget for all departments, worked out on a definite basis of unit cost determined from past experiences that are reliable for calculation; (e) the carrying on of a constant campaign of education for economy among the hospital personnel.

Much has been said and written concerning economy in hospitals; much has been accomplished in this respect. It is well, however, to throw out a warning of the ever present danger of interfering with efficiency. The competent administrator will always be on guard against this possibility, for at no time must the patient suffer through the enforcing of this desirable principle.

Food Greatest Source of Waste

There is possibly no other institution where waste can be so extensive unless there is constant vigilance on the part of all connected therewith. Food and supplies of all kinds offer the greatest source for wastage, and therefore must be carefully watched at all times. In addition, there is the usage and care of furnishings and equipment, which are expensive and warrant special attention. It is quite evident that by intelligent planning of hospitals many steps could be saved and waste of energy prevented. In equipping an institution time and energy can be conserved through the installation of labor-saving devices, many of which are now on the market and have proved their worth. These are only a few of the sources of wastage that should be constantly checked up.

The care of the patient and the end results obtained depend to a great extent on the hospital procedures carried out. These fall into two classes—administrative and technical, which are in most instances inseparable, it being difficult to draw a definite line of demarcation between them.

They are equally important to the efficiency and welfare of the institution. They should be worked out, carefully applied under supervision, reviewed at frequent intervals and revised as often as necessary.

Hospital procedures can be standardized to a far-reaching extent, promoting efficiency and economy without curtailing initiative. Care must always be exercised in not limiting or destroying initiative in hospitals. This would be a distinct mistake. The setting up of standards should tend to stimulate initiative in producing something better. A standard, if properly developed, is the best of its kind or type known at that particular time. It is not necessarily permanent, and should be replaced as soon as a better one is produced. Therefore there is always abundant opportunity for initiative in the presence of standardization, not only in the applying of already set-up standards, but in the devising of new ones better than those already established.

What Ten Years' Effort Has Done

The American College of Surgeons, through its hospital standardization program, is endeavoring to promote the standardization of administrative and technical procedures in hospitals. Ten years of successful endeavor has done much to set the course more clearly and stimulate hospitals to progress towards maximum standards. Hospitals, through this means, are now more than ever speaking a common language as they gradually adopt common principles to guide action and methods of procedure.

The original minimum standard of the American College of Surgeons has been in effect for over ten years, without much modification. This standard lays down fundamental principles of conduct and procedure which, in their proper interpretation, have to do with the best care of the patient. These are simple, practical and adaptable to all types of institutions caring for the sick.

It is interesting to note that in recent years numerous smaller minimum standards have been developed from the parent standard, and so today there are a number of these pertaining to the various departments of the hospital, such as clinical, laboratory, x-ray, records, out-patient, treatment of fractures, traumatic surgery, nursing and dietetics. These are, of course, voluntary and suggestive in character, setting the compass in the right direction and marking the course to follow. These are not fixed and inflexible; they are adaptable and adjustable to variable and changing conditions.

From an exhaustive study of this matter it is found that as a general rule minimum standards

for hospitals embrace five fundamental principles or requirements, the details of which can be readily worked out and applied. These are:

1. **Organization.** The hospital has many departments, each of which must be properly organized under competent supervision and direction. Organization, as already indicated, defines functions, duties, and relations in order to promote smooth running efficiency and other features that should characterize such an institution. This is, naturally, the first principle to lay down.

2. **Adequate facilities,** administrative and technical, such as diagnostic and therapeutic, are essential. A good physical set-up is necessary. All facilities, of course, should be under trained and competent supervision and direction.

3. **Personnel.** It is important that there should be carefully selected adequate personnel, competent in their respective fields of activity. This applies in an equally important manner to all departments.

4. **Records.** Regardless of what department or activity is concerned, comprehensive, readily available records are essential. These records should show the actual performance of the hospital in its various activities. Without these a hospital is like a clock without hands—running, but giving out no information as to whether it is right or wrong.

5. **Conferences.** The getting together at regular intervals for review and analysis of the performance of the hospital through its various departments is of great value in determining causes of inefficiency and ways and means of promoting greater efficiency. Progress cannot be made without an analysis of results obtained.

Standardize Departments

A complete, practical and efficient standard along the lines suggested can be developed for every department in the hospital, with such special modifications and interpretations of details as are required. The following departments in the hospital lend themselves readily to the application of carefully thought out standards: (a) Clinical, such as medicine, surgery, gynecology, obstetrics and other departments or particular features thereof, such as traumatic surgery and treatment of fractures. (b) Diagnostic and therapeutic departments, such as clinical laboratory, x-ray and physical therapy. (c) Other departments included in the general administration and operation of the hospital, such as nursing, dietetics, social service, housekeeping, business, engineering and mechanical and laundry.

To sum up, I would recommend:

That administrative and technical procedures in

hospitals be properly evaluated from time to time and revised, if necessary, in the light of present knowledge and past experience, based always on the care of the patients and end results obtained.

That administrative and technical procedures be standardized so far as possible and practical.

That hospitals generally use as a guide the existing, well thought out standards of practice of the present day, as set forth by the American College of Surgeons and other authoritative organizations in the hospital field.

There Is Room for Initiative

That the standardization of procedures should not in any way curb initiative in the carrying out of the details and the developing of new and better standards from time to time.

From the foregoing it is quite evident that the Class A hospital is a distinctive institution, characterized by the following features:

1. The exercise of the broadest functions in the community—the care of the sick; the education of doctors, interns, nurses, and hospital personnel; the prevention of disease and the promotion of scientific medicine.

2. A well equipped and furnished physical plant suitably located and conducive to the safety, comfort and scientific welfare of the patient.

3. An adequate competent staff or personnel for administrative and technical purposes.

4. The development of minimum standards for the various departments, setting forth organization, facilities, personnel, records and conferences.

5. An efficient administration, characterized by proper organization, coordination, cooperation, efficiency, service and economy.

6. A comprehensive, readily available system of records of performance throughout the various departments of the hospital.

7. Well considered administrative and technical procedures, standardized as far as possible.

8. General and departmental conferences at regular intervals for the analysis of performance throughout the institution in order to determine ways and means of increasing efficiency.

I regret that owing to the need for brevity I have been obliged to withhold numerous details that might have made this paper more explanatory. It is impossible to set forth within the range of this paper a standard for each of the various departments or activities indicated; much of this is being worked out and applied at present. When a standard for each has been developed and successfully tried out only then can a comprehensive scheme of grading be carried on, and until that time we must be content with a more or less general classification.

COORDINATED EFFORT BRINGS BETTER SERVICE*

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SPECIALIZATION in medical practice has been an inevitable outcome of the development of medical knowledge. That the individual practitioner of medicine can no longer cover the entire field is generally accepted. A number of individuals must share the responsibility formerly assumed by the family physician.

With the need for consultation and team work becoming more and more a daily requirement, different communities have projected different schemes. The idea suggests itself that if such consultation between a group of specialists could be arranged in one building, definite advantages would result and the patient would be spared the inconvenience of going from one office or laboratory to another. In different localities, moreover, the plan of reorganization to take care of the out-patient seems to have been determined by the type of previously existing medical institutions.

In our Western states, especially in the smaller communities, well endowed general hospitals have not been as numerous as in our larger Eastern medical centers. It has followed therefore that where physicians wanted to obtain hospital facilities they were obliged to provide them through their own personal resources, frequently on the basis of stock companies. Privately owned institutions, governed by physicians, were more or less the common custom. In such communities the private group clinic for examination and treatment of ambulant patients would therefore be readily accepted as a logical scheme of medical readjustment.

Privately Owned Hospitals Rare in East

In the East, however, where the larger, endowed hospital has been more generally developed, privately owned hospitals, in the form of stock companies, have been the exception. The problems of specialization in medicine have been met by expanding existing institutions, which are usually community organizations, governed by a lay board of trustees. The medical services have been divided and subdivided and the medical staff expanded to provide the necessary division of function and responsibility. In other words, the facilities for consultation, group study and medical

team work for ambulant patients have been evolved from our former hospitals, without changing the external appearance or designation of the organization.

Before proceeding with this study of group clinics it seems important to point out this difference in local background, which would account for geographical distribution, at least in part. It is especially in our Middle Western states that the group clinic has seen its most extensive development. It is true that the influence of the Mayos and the success of their work lent considerable interest to the development of group clinics. However, some of them had their beginning before the Mayo Clinic, Rochester, Minn., was in existence, though in more primitive form. As has been suggested above, these early efforts may express an attempt to establish some kind of medical organization that would serve the purpose fulfilled by the endowed hospitals of our Eastern centers.

Group Practice Development

During the post-war readjustment period there was a rather sudden development of the group practice scheme. It was a subject under active discussion for a time and there were many advocates for and against it. For this reason the Committee on Dispensary Development, New York, was anxious to include a study of this form of medical organization before terminating its six years' study of out-patient service in the United States.

Preliminary investigation through written inquiry had not resulted in any conclusive or authentic information. Through the rather indiscriminate use of the term "group clinic," as a sort of trade designation, various lists obtained through several sources had been found misleading, in the sense that many of the names and localities mentioned were only partnerships or associations of two or more physicians, under a new name that was not descriptive of their activity. It became evident that reliable information as to the work and scope of group clinics could be obtained only through personal visits and actual first-hand studies.

It was under these auspices, therefore, that this study was undertaken in November, 1926. Owing to the limited time available it was possible to visit only fifteen such institutions, selected on the basis of existing information. This selection and

*This article is based upon personal visits and a study made in November, 1926, of fifteen group clinics, in the middle-western states. The study was made at the request of and under the auspices of the Committee on Dispensary Development of the United Hospital Fund of New York. The complete report, of which this article is an abstract, may be obtained on request from the Associated Out-Patient Clinics Committee, 244 Madison Avenue, New York.

the course of itinerary turned out to be fairly well chosen and led to some interesting discoveries. It was found that among the group clinics themselves a certain select number had recently held a conference to discuss mutual problems and the possibility of effecting a permanent organization, with a view of adopting minimum standards and defining the limitations of the term "group clinic" to such as were definitely organized, where all financial and fiscal matters were relegated to a business manager, where all fees were collected by a business office and the income pooled, the medical staff members receiving certain fixed shares of annual profits or income, and where the patients were referred to and treated by the member of the group best qualified to handle the case—in other words, an organization directly comparable to at least the private and semi-private service of our large endowed hospitals, with the expressed desire of providing better medical service in their communities.

It is of interest, also, that while the majority of clinics participating in this conference were in the states of Michigan, Wisconsin, Minnesota,

No attempt will be made here to enumerate the various details of their organization and administration. These differed somewhat in each of the fifteen groups studied. And it might be proper to state that in limiting this study to the fifteen clinics actually visited, it is with the definite reservation that a fixed schedule of itinerary made it impossible to visit others that might have offered even better examples of organization and medical service than those studied. The outpatient departments of four teaching hospitals were included in this tour of observation, by way of comparison and on account of personal interest in medical education methods. The fifteen group clinics visited included the Mayo and Cleveland Clinics, which stand out from the others by their magnitude and national reputation and whose work is so well known as to require no description.

A clearer picture may be introduced by a concrete illustration. A typical group clinic in a city of 48,000 inhabitants in one of our Western states has a modern two-story building of brick and stone on a pleasant street, centrally located, but off the commercial center. The entrance is at the street level, through an ornamental doorway and an inviting vestibule leading to the spacious and comfortably furnished waiting room. A neatly uniformed and intelligent desk attendant receives the patient and obtains the necessary identifying information. The patient is then ushered into the examining office of the physician to whom he has been referred, or to whom he is assigned for the initial examination. The offices are arranged along a corridor surrounding the large central waiting room. This affords facility for free consultation and exchange of ideas. A well equipped laboratory and x-ray department provide means for the usual routine diagnostic procedures.

No Crowding

There is no crowding, no massing of patients in large numbers. They come in singly, at intervals, in the course of the clinic working day from eight to five o'clock, with late evening office hours three days a week to accommodate some of the industrial workers. The staff includes seven physicians and surgeons, the majority of them young, who have gathered about one of the leaders of his profession, one of the "old school" doctors, who has been in practice for more than forty years. A graduate of one of the leading universities of the country, he realized that as medical science advanced no one man could hope to master all this new knowledge. He is exchanging the mature judgment, acquired through

SCHEMA FOR CLASSIFICATION OF GROUP CLINICS				
ITEMS OF ORGANIZATION	TYPES OF ORGANIZATION			
	Primitive	Transitional	Administratively Organized	Medically and Administratively Organized
1. Relation of members of group to patients: (a) Each member treats patients individually (b) Patients assigned to that member best fitted to care for case.	✓	✓	✓	✓
2. Consultations: (a) Arranged among members, as in individual practice (b) Arranged according to rules fixed by group	✓	✓	✓	✓
3. Ownership and control of capital: (a) In the hands of one physician or an outside commercial body or individual, each member of group paying rent (b) In the hands of an outside individual or organization with which group as a whole has agreement (c) In the hands of the group itself, or a holding company which members of the group control	✓	✓	✓ a ✓	✓ a ✓
4. Distribution of income: (a) Received independently by each member as in individual practice (b) Income pooled—net income distributed according to agreed shares (c) Income pooled and net income distributed on an agreed salary basis	✓	✓	✓ a ✓	✓ a ✓
5. Determination and collection of fees: (a) By each doctor, as in individual practice (b) Determined by each doctor; collected by central office for each doctor (c) Determined by fee schedule agreed on by group; collected by central office and pooled	✓	✓	✓ a ✓	✓
6. Office and Laboratory facilities: Used in common	✓	✓	✓	✓
7. Office and laboratory expenses: (a) Prorated among doctors directly (b) Pooled and deducted from gross income	✓	✓	✓	✓

a = Alternatives.

Illinois and Iowa, some of them were in southern, southwestern, Pacific Coast and Eastern states, and one was in Canada. In other words, the selection had evidently not been influenced by local geographical considerations, but by assumption of certain professional qualifications.

a life of medical practice, for newer ideas resulting from medical research, and is being broadened and enlightened through association with younger minds. He has given his library, acquired in the course of years, for the general use of the group, or any other physician of the com-

the founders and members have constituted themselves separate holding companies for the building and equipment. Only one instance was encountered where the group was incorporated as a stock company.

Of the various features noted, the character of

Kenosha Clinic, Kenosha, Wis., where the group practice scheme has been developed.



munity who cares to consult it in the clinic building. Here the staff members meet at frequent intervals to discuss interesting cases or hear the report of some recent medical meeting.

In contrast to this there were found "organizations" designated as "group clinics" or "private clinics" which on very slight investigation were found to be merely a trade name for the office of an individual physician who might have one or two assistants. A more worthy example listed among group clinics was found to be simply an association of two physicians sharing the expense of office facilities. It was housed in a typical commercial building in the business centre of the city, on the second floor, flanked by the usual motley group of lawyers and real estate brokers.

As has been pointed out, group clinics are private enterprises, established through private means. Community or public funds have not been contributed so far as is known except in one instance, that of the Grand Rapids Clinic, Grand Rapids, Mich., where business men of the community raised funds for the clinic building at a cost of \$200,000, and turned it over to the group as a holding company. In the case of the Mayo and Cleveland Clinics there are substantial endowments in addition to the buildings and equipment that have been contributed and turned over to the clinics by the founders themselves, in the form of a trust deed, in order to insure perpetuity of the work. In some of the smaller group clinics

buildings, appointments and equipment impressed one as adequate. Seven of the clinics occupied buildings that had been built especially for the purpose. These were well designed, with a view to facilitating interdepartmental refers or consultations, and routing patients from the registration desk to the different stations or examining rooms. All of the clinics visited were using good record forms and had a central filing system. Some hospital affiliation was found to exist in connection with all of the clinics visited. Either the clinic members or staff were identical with the hospital staff, or at least dominated the medical board. Some hospital directly affiliated with the clinic was considered an absolutely essential condition. This has been developed to the highest degree in the Mayo and Cleveland Clinics, where the hospitals are, in part, immediately contiguous to the clinic building proper.

While none of the clinics visited limited their work exclusively to diagnosis and consultation service, they all professed a desire to do this kind of work for other physicians. The consultation work would usually increase when after a survival of some years the clinic had succeeded in winning the confidence of the local profession. This was usually more difficult in the smaller communities where local professional jealousy had been encountered more frequently than in larger cities.

Group clinics being private enterprises and not

required to supply reports to either official or voluntary agencies, it is difficult to obtain reliable information as to their financial affairs. It is a delicate matter to ask questions too pointedly. However, on the basis of statements offered, often supported by outside testimony, it was found that the charges made to patients were usually similar to those in vogue in private practice in the given community. There was no tendency to charge less and in that way compete with the individual practitioner. On the other hand, there was an absence of any evidence that the patient was being exploited commercially, except in one instance.

Cross Section of Community

The classes of patients seen in the different clinics reflected a cross section of the community in which they lived. Their appearance was just what one would expect to find in the private office of any doctor in the given community. Little information could be obtained as to medical statistics, except the approximate total number of patients treated in a year or the total number of actual patient visits. No reports were available as to distribution of administrative overhead costs and other administrative data that would be of interest in making comparisons with public or privately endowed institutions, under lay boards of trustees or governors.

Obviously the quality of medical work done by a clinic group will depend upon the ideals, qualifications and ability of its medical staff. It would be difficult to judge this fairly without a longer time for observation, a study of progress records in given cases, and some opportunity to come in closer contact with the inner soul of such a group, through intimate contact or by actually living with them. The general spirit, intelligence and professional attitude must remain the criterion upon which to estimate medical service. The general reputation in the community among medical agencies, and especially among medical teaching institutions, would constitute supporting evidence.

On this basis the groups visited were apparently led by men of good medical education who were imbued with the sincere purpose of providing better medical service to their communities and dealing fairly with the medical profession. In different instances, in widely distant localities, the statement was made by leaders or members of these groups that they could probably increase their income considerably if they were in practice for themselves, but that they enjoyed the satisfaction of practicing better medicine.

Opponents of the group clinic scheme have sug-

gested that there is a tendency to subject the patient to unnecessary diagnostic procedures and incur unwarranted expense. The same thing might be done by individual practitioners and probably has been done, both by groups and individuals. The group would be guided in its conduct by the spirit and ideals of its dominant members or founders. Its ideals would be those of the individuals composing it.

There has been considerable antagonism against the group scheme in some localities on the part of the outside medical profession. At the same time this has found its expression largely in the form of individual comments. The same antagonism was manifested against the Cornell Clinic, New York, when this was reorganized and established on a pay clinic basis some five years ago. Its inception was viewed with serious misgivings by some of the officers and by the faculty of the university itself. In spite of these dire forebodings it has grown and expanded, and nearly four thousand individual physicians practicing within the New York metropolitan area have made use of it and are continuing to use it for diagnostic and consultation service, or are sending patients for health examinations, when they feel that they are not personally equipped to give this service.

Innovations Are Distrusted

At a time when the practice of medicine is undergoing a transition, any innovation is apt to be viewed with suspicion. We fear what we do not understand. Electric light in homes and electric traction were first demonstrated by our western communities. It is not so long ago that the first suggestion of a medical office building in New York City was viewed with considerable apprehension by the more conservative members of the profession who had grown up under the tradition of combined office and dwelling. For a woman of high society to have her baby born in a hospital would have been considered almost a scandal not many years ago.

If it had no other merit the group scheme of practice would at least be an interesting experiment in a method of applying the art of medicine by private practitioners, governed by themselves, just as our modern teaching hospital with its admission and diagnostic service, out-patient department and private pavilion, is a well developed experiment in applying the art of medicine in an institution, governed by a lay body. In the first instance the business management is controlled by the physician, the physician having provided the capital funds, and in the second the physician is controlled by the business managers,

the funds being provided by the outside public or the community.

If we accept it as conclusive that the science of medicine has become too large a field for any one man to master, it follows that the efforts of a group of men coordinated as a team in one building, with continuity of study and observation, would offer the individual patient better service in the way of diagnosis and treatment, than where such correlation is developed without personal conference and free exchange of thought in weighing evidence. Speaking again of our experience at the Cornell Clinic, the need for more interdepartmental personal conferences is a matter that both the director and the medical staff have been emphasizing during the last year. On account of our growth and expansion these conferences have been difficult to maintain.

What Is a Group Clinic?

In conclusion it may be well to state a tentative working definition as follows: A group clinic means a self-determining organization of a number of physicians occupying offices in the same building, with some form of agreement concerning the assignment of patients, the use and control of the plant, equipment and assistant personnel, and the distribution of financial returns among the participants.

It is distinguished from individual practice by the fact that it is organized, and from the usual hospital organization by the fact that it is determined by physicians themselves. In a hospital the ultimate control is in the hands of a board of trustees representing the public which has provided the capital without expectation of financial returns. In the group clinic the capital is usually provided by the physicians, or secured by them on a business basis.

The above elements are shown in tabular form in the schema on page 76.

Defines Group Clinic

It seems desirable that certain limitations be placed on the term "group clinic," and that it be confined to those clinics that have established a definite, stable and close organization; that are actuated by the aims and ideals of better medical service to the community; in which there is an assignment and refer of patients to those members best qualified to handle the given case; in which there is actual personal contact and consultation between members of the group and not merely written exchange of memorandum opinions; and, finally, where, in order to minimize the commercial aspect, the division of income or profit is based upon some fixed annual agreement and

not upon the current volume of work per individual.

More than a sentimental regret is felt that many communities no longer enjoy, to the same extent as in the past, the educational influence and leadership of the old type of practicing physician, the "family doctor," who had grown up in the locality, who, knowing the intimate histories of its families, had developed the human qualities of deep understanding and sympathy, and whose advice and guidance would be sought in all matters, communal and individual. However, in this age of specialization, organized team work has become essential in industry and the arts. In the art of medicine, how far is team work equally expedient? We have such team work exemplified in hospitals and clinics which are governed by trustees who represent the community. We have such team work in another form in the group clinics with which this report is concerned. How large a part will they play in the medical practice of the future? The present study can do no more than lead up to such questions.

THE RELIEF—THE FIRST VESSEL DESIGNED AND BUILT AS A HOSPITAL SHIP

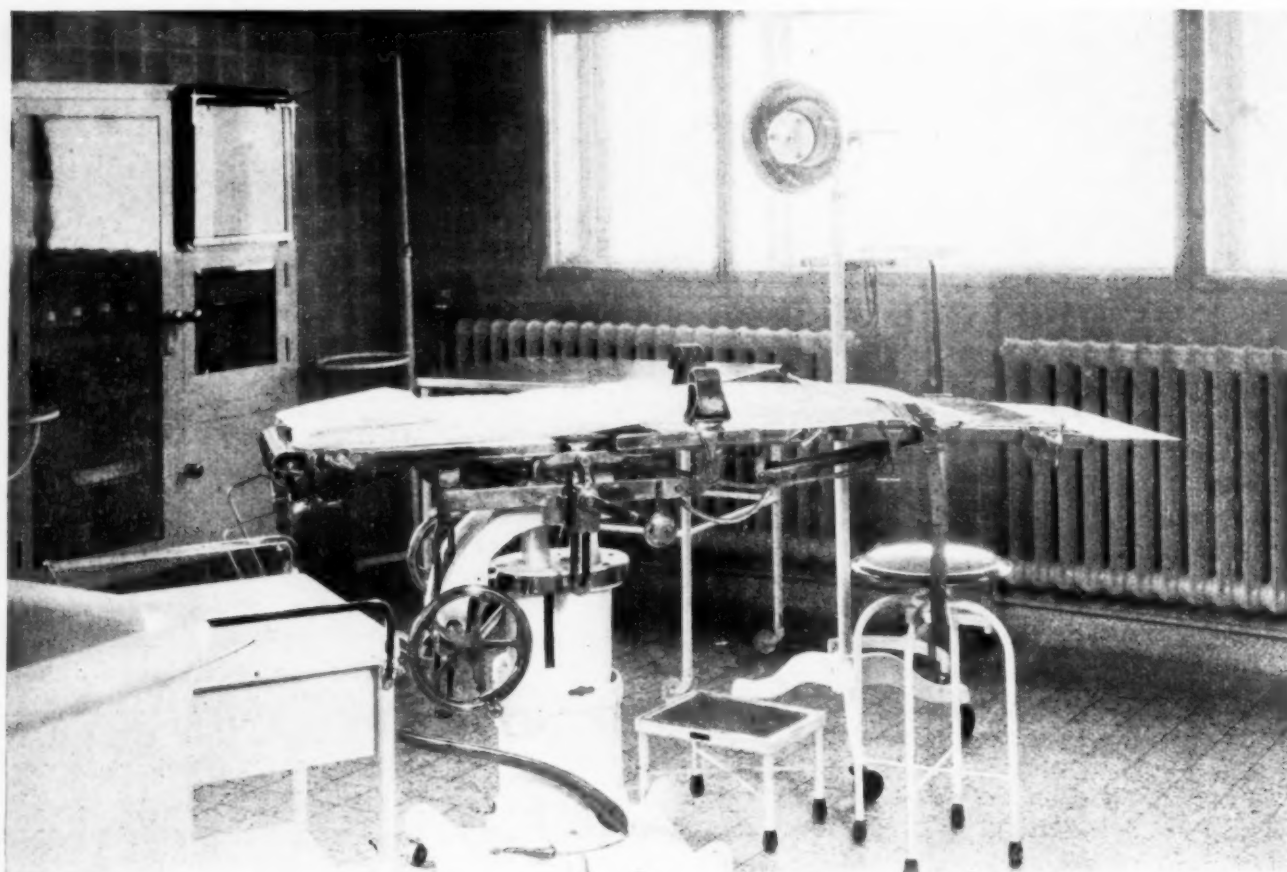
The hospital ship *Relief* is the only ship in the world designed and built from the keel up for use as a hospital ship, says the *Medical Journal and Record*. In addition to being prepared to care for the sick and injured of the fleet, to the number of 500, the ship is also fitted as a fleet medical depot so as to fill the ships' requisitions for emergency medical supplies. She also has provisions to carry in her hold a field hospital with tentage, drugs, instruments, ranges, cots and ambulance, so that in time of emergency she would place with a landing party on shore a field hospital ready for service, with 500 beds.

In the hospital division of the ship are fourteen wards and rooms for nineteen sick officer patients. At the port and gangway entrance are small operating rooms or dressing rooms. Here the injured cases may be received and cleaned up before being sent to the wards.

The *Relief* has a splendidly planned operating room, two decks in height, with excellent natural and artificial lighting and ventilation, and with such accessory rooms as etherizing room, scrub-up room, sterilizing room, dressing room and lobby. These rooms are on the upper deck adjacent to the sick officers' quarters. She has special isolation wards for patients with contagious diseases and an elaborate electrocardiograph instrument, the only one afloat in the world.

For the preparation of food there is a main galley and special diet kitchen. The main galley prepares food for the ship's personnel. The special diet kitchen is fitted with electric ranges and various other appliances for preparing the special diet for the sick. From this room the food is routed to the various ward pantries and to the bedside, by means of portable cafeterias.

Twelve nurses of the Nurse Corps of the United States Navy are assigned to duty on the *Relief*, in addition to 110 hospital corpsmen trained as nurses who serve on the vessel.



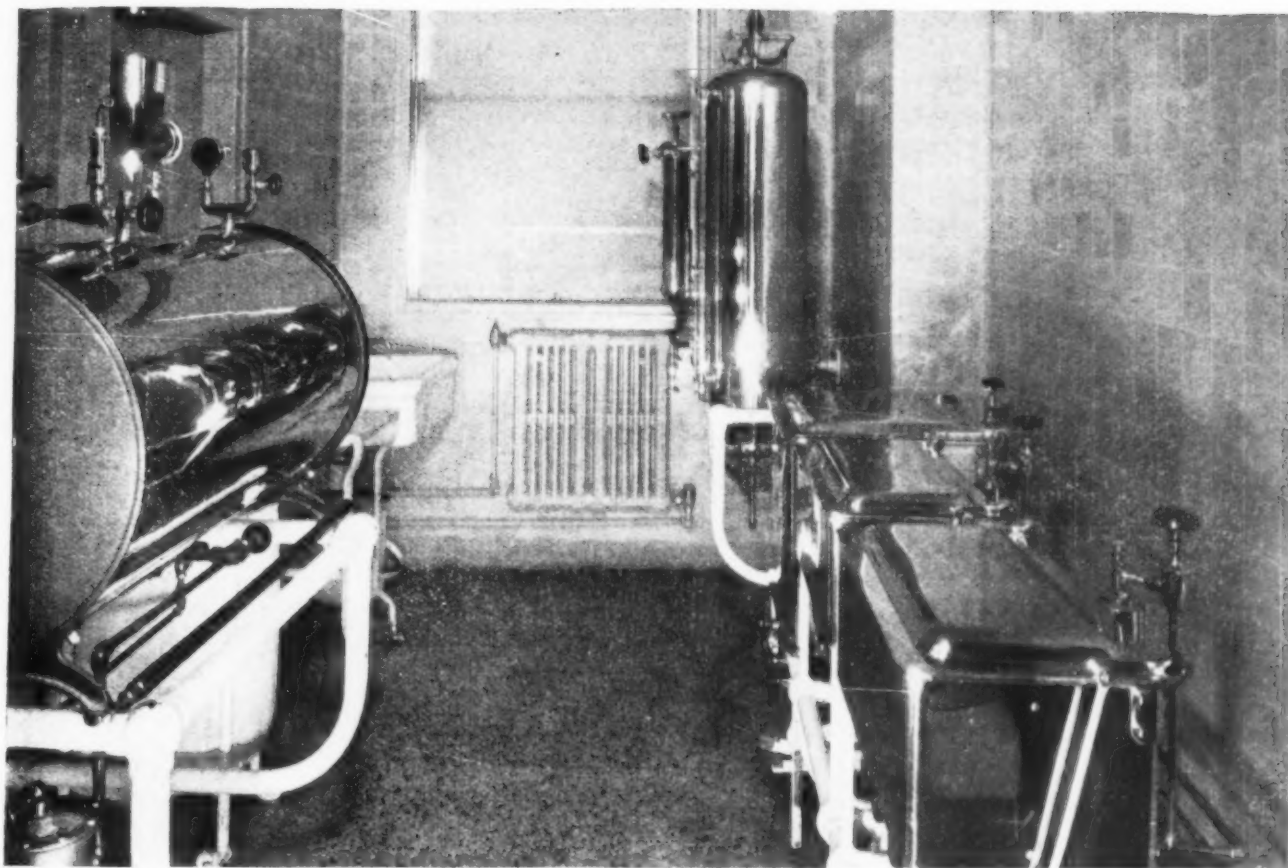
Operating room.

Interesting Features of

Delegates to the A. H. A. convention will

Obstetrical room.





Metabolism room.

Northwestern Hospital

do well to visit this Minneapolis hospital.

Sterilizing room.



GUIDING THE PATIENT'S THOUGHTS INTO CHEERFUL AND WHOLESOME CHANNELS

By Edward F. Garesché, S. J.

Milwaukee, Wis.

WHAT do patients think of when they rest quietly in their rooms, their bodies prostrated with illness or languid in convalescence, but their minds sometimes active and their eyes and ears alert?

It would be interesting and profitable for hospital workers if they could know the thoughts that pass through the patient's mind. Sometimes it would be encouraging to find how much appreciation and gratitude have a place in the patient's thoughts. At other times it would be stimulating to learn the critical and sometimes indignant feelings that arise in the patient's mind, though they may never find expression on his lips.

The reputation of the hospital, at least as far as the general public is concerned, is in great measure a result of the thoughts of the patients who have passed through it. The impressions that each one receives are blended together into a composite judgment of the hospital. These impressions are carried away by the patient, and are made known repeatedly to friends and acquaintances. In time they crystalize and represent the attitude of the public toward the hospital. Every time, therefore, that a hospital worker, through kindly and efficient service, gives occasion for grateful thoughts in the mind of a patient, that worker contributes to the building up of popular favor for the hospital.

The Sick Are Easily Influenced

The thoughts of a patient flow in a large stream that never ceases during waking hours and continues its course even in the land of dreams. Sometimes the stream is calm and clear, at other times it may be vexed by the rapids of fever or the waterfalls of delirium. But in every head on every pillow the thoughts flow on unceasingly.

It is the precious privilege of the hospital worker to brighten and cheer the patient's thoughts. The sick are easily influenced. Through suffering and weakness they have become almost as docile and impressionable as children. The nurse takes care of them as a mother does of her children, and, if she wishes, she can exercise over them a motherlike influence, directing the stream of their reflections into wholesome channels and encouraging them to have healthful and cheerful thoughts that will profit and console them.

Those who deal with the sick have a duty, for

their patients' sake, to make their own personality as complete and beautiful as possible, so that they may be able to influence for the better the current of their patients' thoughts. The old proverb tells us that no one can give what he does not possess. To communicate to others wholesome and noble thoughts, our minds must be wholesome and noble. From the empty mind comes mere chatter, the claptrap of banal conversation, remarks about the weather, gossip, the mere froth of the daily news, commonplace things that have no power to enrich or cheer the patient. Reading, study, thoughtfulness, the harvest of a quiet mind and a tranquil eye are necessary before one can influence for good the thoughts of others.

Aim High

Every mind has possibilities of noble and elevated thoughts. Unhappily, the tendency of most men's thoughts is toward the trivial, the ordinary, sometimes the evil. Yet the same mind that dwells with complacency on the insignificant mixture of news and scandal retailed in the daily press can dwell with great pleasure and satisfaction on themes that are noble and pure. There is in everyone something of the angel. All of us have better selves, which sometimes come uppermost and always yearn for expression. The hospital worker who has a mind attuned to high ideals will be able to strike the right note in the minds of the patients, and so set their thoughts vibrating with sweet music that will cheer and control their whole being and promote health as well as contentment and peace of mind.

Every hospital worker, therefore, should scrutinize his or her own personality, and determine what is to be done and what endured in order to raise and ennoble it so that she may become a good influence over others. Reading, of course, is the most powerful means whereby the hospital worker can enrich her mind. The world of books lies forever at our feet, and in it are many pleasant paths, well traveled highways and shady byways, where minds can wander in pleasant fields and pastures new, or can saunter through leafy solitudes, communing with the great minds of the past.

Reading is the most delightful of all recreations to well trained and well balanced minds. It is

significant that in spite of the multiplication of commercialized amusements, the ancient pastime of reading is not only holding its own but is increasing in popular favor. Yet it is to be feared that too few hospital workers are great readers and that too many merely nibble at current literature, without making any effort to enrich their minds. Consequently, they have nothing to offer to their patients and can only chatter unprofitably.

Mental Cases Need Help

Yet experience shows the great efficacy of helping the patient to think of interesting and profitable things. Not long ago we listened to the experiences of a director of an institution for mental cases in which this worker spoke of the personality of the nurse as the most important influence over the patient. The nurse who has real resources of culture, who is acquainted with music and literature, who has some knowledge of art and some appreciation of culture is far more effective with mental cases than the nurse who lacks such resources. It is she who, by furnishing wholesome topics of conversation, by leading the mind of the patient into pleasant paths, can best "minister to a mind diseased." She can "pluck from the memory a rooted sorrow" by conversation which is engrossing in its interest, and "with some sweet oblivious antidote" of congenial and elevated thought she can "cleanse the stuffed bosom of the perilous stuff which weighs upon the heart." Thus Macbeth's sage summary of mental treatment, when he questions his wife's physician, may be carried out by the truly cultured nurse. Nor does the answer of the doctor, "therein the patient must minister to himself," invalidate the remedy of the nurse's influence. For by influencing the patient's thoughts the cultured nurse can help effectively to stimulate the patient to minister to himself.

The first requisite for this personal culture is, of course, the will to read, to think, to take an interest in the elements of culture. Nowadays everyone reads. It is in the choice of the reading matter or in the failure to choose at all that the difference between hospital workers is found. Some persons spend many hours in reading, but it is of such a desultory sort that it does not enrich the mind, but rather dissipates the thoughts. Spend an hour with the Sunday paper and you will rise up with weary eyes and mind, with a little headache perhaps in the center of the forehead, with only a confused notion of what you have read, and with thoughts more scatter-brained than when you sat down to read. But give an hour to the quiet perusal of a worth-while

book and you will rise up strengthened, refreshed and comforted.

The books we read help to form our character, as does the company we keep. We can choose the persons with whom we associate, but we cannot help being influenced and impressed by their companionship. Neither can we help handing on to others the influence that we ourselves have received. When you read a really excellent book, just as when you make a really noble friend, you confer the benefit on everyone with whom you come in contact. As there is a contagion of evil, so also there is a contagion of good.

To have good books always at hand is one means of encouraging oneself to take a personal interest in culture. It is not difficult to get lists of books that are approved by persons of good judgment. In every city of any importance the library will willingly obtain the volumes you ask for if they are not already on the shelves. Never was there a time when access to the fountains of culture was so easy, and never was there a country where the libraries were more obliging than they are in ours. But it is also true that there has seldom been a time or a place that offered more opportunities for or temptations to desultory reading. We have continually to exhort ourselves and others to use discrimination in our reading or we shall follow the line of least resistance, and shall thus be unable to suggest any really worth-while thoughts for our patients because we ourselves have failed to obtain any inspiration from what we have read.

Suggest Right Kind of Literature

If the hospital worker loves good books she will be able to serve her patient by suggesting the reading of some worthy books that will enrich and gladden the patient's thoughts. How little the therapeutic value of good books is comprehended or utilized in hospitals! There is much talk of psychology, of psychiatry, of mental states and mental remedies, but how seldom we find a hospital where the cordial, invigorating, cheering influence of good books is utilized in any systematic way.

In the hospital of the future, no doubt, the nurses will be trained to be good readers, with pleasant, well modulated voices, and the power of intelligent interpretation. To read to the patients who are in a position to profit by such a service will be one of the accepted features of nursing. The patient's thoughts will then be an object of real solicitude. When that happy time arrives hospital workers will look back with surprise on our era, when so little attention, relatively, is paid to the thoughts of the patient, and will wonder

what we were thinking of to give so much care to many material things and to pay so little attention to what concerns the mind, the heart and the soul of those intrusted to our care.

Besides reading, other influences powerfully sway and control the current of the patient's thoughts. The whole environment of the sick person influences his mental state. To lie for hours and days in a bleak and cheerless room, shut in by blank walls, without any relief of color or form to rest the eye, is depressing and disheartening, even to a well person. How much more, then, are the sensitive minds of the sick depressed by ugly surroundings.

Harmony Should Prevail

Neither should the sick person's surroundings be too exciting, glaring, disturbing. Harmony, tranquility and beauty should characterize the sickroom in its decorations and its pictures. It is no more expensive in terms of money to have a beautiful hospital than an ugly one. It costs only care, solicitude, time and thought, and if the hospital authorities themselves cannot afford this time and effort they ought to employ someone with trained good taste to plan the pictures and decorations of their rooms. Better still, there should be someone in the hospital who is specially educated in the tasteful choice of colors, of decoration and of pictures. He or she should perseveringly work to make every room or ward in the hospital a place of tranquil beauty, so that the patient's thoughts will be directed towards peace.

Some persons object to pictures in the patient's room on the score that they excite the patient's mind and weary his eyes. It depends very much, of course, on what the pictures are and what is the state of the patient. In some mental conditions it might be advisable to remove pictures. In other cases it would be well to choose the pictures very carefully. To avoid monotony, the pictures might be changed from time to time where a patient remains a long time in the hospital. It would not be difficult to have on hand many beautiful pictures, simply framed, which could be changed from one room to the other. All this requires thought and care, but what a precious thing it is to cheer and calm the disordered fancies and the feverish thoughts of even one sick person.

One can obtain beautiful photographic reproductions of the great masterpieces at such a reasonable rate nowadays, colored by hand and thus approaching the original to a degree difficult to achieve in lithographed reproductions. In choosing such pictures for the hospital one ought to select those that are both lovely and inspiring.

Finally, we cannot dwell too often on the importance of the talk that goes on in the patient's room. What we say to the patients and what they hear us say to others have both a positive and a negative significance. We convey information, start trains of thought, influence the mind and the imagination. A word may start a whole train of reflections in the feverish and active mind of some patient who is merely lying there and thinking, hour after hour. We ought to be careful that everything we say to the patient is wholesome, cheerful, inspiring. To give a patient helpful and cheerful thoughts is sometimes better than any amount of careful dosing with medicine. If we ourselves were ill, weary, and suffering, how much we should appreciate being given some bright thoughts, to light up and cheer our minds. It is not so much the state of the body that makes life miserable or happy, but the state of the mind. Many, many persons in complete health are restless, and many sick persons have a tranquil and contented mind. We should always be alive and sensitive to the influence of our talk.

In the midst of the exacting demands of hospital work, the preoccupations and wearinesses of every day, it may seem to many too much to expect that the hospital worker should be concerned with the patient's thoughts. People come to the hospital to be ministered to physically, they may say. It is the body and not their mind that is the object of hospital care. The first reply to this objection is, of course, that the mind has so powerful an influence on the body that the care of the body must necessarily be the care of the mind. Again, the hospital is continually dealing with men and women whose mental state is not normal. For every person who is ill has something hardly normal about his mind.

Treat the Whole Man

Then again, it is not only the body but the whole man or woman that is committed to the care of the hospital. You cannot possibly minister rightly to the body without considering the mind. There was a time when dosing with drugs was the chief stand-by of hospital workers and physicians in general. Little by little physiotherapy has been accepted. The next advance in ministering to the sick, which went hand in hand with physiotherapy and in many cases preceded it, was the treatment by serum and antitoxin. But we need a further step forward in the treatment of the sick, we need to pay more attention to the mental state of the patient, to study his surroundings, the conversation and reading we offer him, the companionship and influence brought to bear upon him.

CORRELATING THE HOSPITAL PROGRAM WITH THE HEALTH NEEDS OF THE POPULATION

By Willard C. Rappleye, M. D.
New Haven, Conn.

STATISTICS assembled by THE MODERN HOSPITAL and the American Medical Association show that of almost 7,000 hospitals in the United States, two-thirds are classified as general hospitals.

This group of hospitals contains about 40 per cent of the total number of hospital beds. It is noteworthy that the custodial institutions for nervous and mental disorders represent another 40 per cent of the hospital beds of the country, although they are only 8 per cent of the total number of hospitals. Three-quarters of the general hospitals have a bed capacity of 100 beds or less, and about two-thirds of them are in communities with a population of 50,000 or less, about one-half of them being in towns of 10,000 or less. Even with this wide distribution of general hospitals in small communities there are still 44 per cent of the counties of the United States without hospitals, although this does not mean that hospital facilities are not within reach of the population in many of these counties, some of which are small and sparsely settled.

What is the role of these general hospitals in the health service of the community? How are they related to the medical needs of the population which they serve? Study of the demands for medical attention shows that about 10 per cent of patient visits by general practitioners are in hospitals, two-thirds of the balance being represented by office visits of ambulatory patients and one-third by home visits of the physician.

How Hospitals Are Divided

An analysis of the hospital visits shows that they are divided as follows: surgical, 55 per cent; medical, 30 per cent; obstetrical, 15 per cent. Analyses of the home and office visits show that in addition to minor surgery, respiratory infections, general medical diseases and obstetrics, a large proportion of venereal and contagious disease patients are given care, and that there is considerable demand for the diagnosis and care of nervous disorders, urological conditions, skin diseases, tuberculosis, late syphilis, eye and ear disorders, and diseases of infancy.

Until recently most of the work done in the general hospitals, especially in the smaller institutions, was surgical. The development of surgical asepsis and technique, the necessity of an

organized trained staff of assistants for surgical work, and the gratifying results from the proper treatment of injuries and from major elective surgery have contributed to make the hospital care of surgical problems necessary to insure the best results.

Maternity Care in Hospitals Increasing

The use of hospitals for obstetrics is now increasing rapidly. Although there are about two hundred maternity hospitals in the country, close to 90 per cent of the hospital care of obstetrics is given in general hospitals. Incidentally, the number of independent maternity hospitals has declined about 15 per cent in the last five years. Studies of the percentage of deliveries in hospitals in selected communities with a population of 70,000 or greater (conducted jointly by the United States Public Health Service and the American Public Health Association) show figures ranging from 20 per cent to 40 per cent in many of these communities. In some cities the figures are considerably higher, as illustrated by Springfield, Mass., 60 per cent; Hartford, Conn., 62 per cent; Spokane, Wash., 64 per cent, and Minneapolis, Minn., 67 per cent. These and other data point rather clearly to the fact that a considerable proportion of obstetrical care in the cities is rendered in the hospitals and that there is an increase in the use of hospitals for this type of service.

The great development of laboratory and technical methods, as well as the necessity for trained personnel, for both the diagnosis and treatment of acute and chronic medical diseases, have brought a further appreciation on the part of the public of the value of a hospital period of study and treatment in many of the non-surgical disorders. With the growing recognition of the importance of early diagnosis in certain of the slowly progressive diseases, and of the importance of correcting minor defects which may be contributory factors in more serious ailments, there has been an increasing willingness on the part of patients to go to hospitals before they are seriously ill. The hospital is becoming an essential element in the program of preventive medicine and health conservation. It is attempting to keep abreast of its opportunities and responsibilities as rapidly as money and personnel become avail-

able. Probably few realize how rapid the growth of hospitals has been—a growth that has been over 4,000 per cent in fifty years.

Despite this growth of hospitalization and the extension of the hospital functions into closer relation to the medical needs of the community, there is still considerable unevenness among hospitals in the extent to which the professional functions of the hospital have been correlated with the local problems. Too many hospitals are still merely hotels for the sick, and yet there are indications in many places in the country that even a further extension of professional services is in process.

There is a general recognition, for example, of the importance in active tuberculosis of the removal of the patient from an environment in which there may be children, in order to prevent the children from contracting the disease, it now being recognized that practically all tuberculosis is contracted in childhood. It is highly important that in the fight against this disease prompt isolation of infectious patients be possible and convenient. Special hospitals for tuberculosis are available in most states, but in many instances temporary hospital care and study are important, and there is no reason why local general hospitals should not be ready to render the service required by such patients, under conditions that should provide the necessary safeguards in handling this infection and adequate facilities for the proper care of these patients. Tuberculosis not infrequently involves more than one tissue or organ, and a general study of the patient to determine the most promising method of treatment, and the correction of defects whereby the effectiveness of subsequent treatment may be increased, can be best obtained in a general hospital.

More Mental Cases Need Care

The increase in mental diseases promises to become one of the major economic, social and medical questions with which the individual states are confronted. In the last forty years the number of patients with mental diseases in institutions has increased about four times as rapidly as the population. To give some idea of the magnitude of the problem of mental disorders, it can be stated that the number of new commitments to institutions for mental disease has almost paralleled the increase in matriculation in the colleges of the country, and the institutionalized mental diseases at the present time number almost as much as the enrollment of all the colleges of the country.

Many factors have contributed to this large increase in institutional care for these disorders;

such factors as urbanization, the improvement in the institutions, and the changed attitude of the public toward them (which has made many families willing to have their relatives committed to them), the results of unselected immigration and the increased effectiveness of social, school and other organized social efforts have been operative.

Most mental diseases have a long history and most patients with these diseases show symptoms years before they require permanent segregation or a long period of care. The hope of dealing effectively with this large problem lies in early diagnosis and proper early treatment before irremediable damage is done. The custodial institutions are doing what they can in the program of prevention, but an even more important contribution can be made through the general hospital and clinic facilities in the community itself. Patients with early nervous symptoms are prepared to go to a general hospital for study at a stage when considerable help can be promised, whereas they are usually unwilling to enter voluntarily a custodial institution even for temporary treatment. Frequently the first serious symptoms of mental disorder appear in the nature of an emergency, from which the patient often recovers promptly.

The General Hospital's Part

The general hospital might well be prepared to take care of this type of patient to the distinct advantage of the patient and the community. It is recognized, of course, that in handling problems of this character special facilities would have to be available, but the hospital could probably receive support for the development of such a program because in the long run it means the conservation of mental health and the avoidance in a considerable number of instances of the permanent commitment of an individual who then usually becomes a public charge.

Sound medical care of the venereal diseases is predicated upon a continued period of supervised treatment, early in the development of the disease if the best results are to be obtained. The frequency with which the central nervous system is involved in syphilis, with the subsequent serious derangements that are likely to follow such involvement, suggests the wisdom of such procedures as lumbar puncture before the discharge of the patient with syphilis. Here again the general hospital might well be utilized as a facility for the determination of central nervous system involvement, as well as for the treatment of those patients who require it. The results would not only aid in the prevention of the essentially neurological conditions, but would be a definite

factor in the prevention of mental diseases, inasmuch as about 10 per cent of the commitments to mental hospitals are for general paresis, which is always due to syphilis.

Great progress has been made in recent years in the control of contagious diseases by immunization, by tests of susceptibility and by early use of prophylactic measures. However, there is still considerable incidence of contagious diseases and a definite percentage of these have complications or sequelæ which require general medical or surgical treatment. Furthermore, the contagious diseases that require isolation, active nursing supervision and close medical attention can probably be best taken care of in hospitals, and it seems entirely possible to visualize this care as part of the function of a general hospital, with special provisions for such patients.

What Chronic Patient Needs

Many general hospitals now care for patients with surgical and medical conditions of the eye and ear. In certain instances special recommendations and facilities are or should be provided for this group. The same is true of skin diseases, although few of them are hospitalized or need hospitalization.

A growing interest has recently been manifested in the problem of convalescent care following hospital treatment, and in the care of chronic and incurable diseases. It is clear that these several groups of patients cannot be advantageously taken care of in a hospital for acute illnesses, but there is a growing opinion that the care of this group of patients should be considered along with the general hospital program of the community rather than by provision of detached facilities having little or no relationship to the general hospitals. It is true that the care of these patients makes necessary certain special features, occupational therapy and modifications in the routine handling of the hospital, which cannot be conveniently provided in an active hospital. However, there are many facilities of the "acute" hospital which they do not require and they can undoubtedly be cared for with considerably less expense in units provided especially for them. Nevertheless, the care of this group of patients, which is a considerable problem in the community, should not be divorced from the problem of general hospitalization.

In touching upon the various possible extensions of the function of the general hospital, a mere mention of them suggests considerable outlay of special facilities and this in turn represents added costs for capital outlay as well as for maintenance. Even at the present time many general

hospitals restricted in their functions to surgery, obstetrics and medicine lack adequate numbers of trained personnel and necessary equipment for laboratory work, x-ray, physiotherapy, bacteriology and pathology and dietotherapy, but these various facilities have come to be recognized as necessary for the highest type of hospital and medical practice.

These special types of hospital service have been developing parallel with specialization in medicine. In this last connection there probably is a definite relationship between the distribution of physicians and the facilities for medical practice, although this factor is probably secondary to the more fundamental factor of economics. It is of special interest, however, that approximately 40 per cent of recent graduates in medicine limit their practice to a specialty and that an equal number, while engaged in general practice, are giving particular attention to one of the specialties. Recent medical graduates are locating in the larger and more prosperous communities and at centers where there is a considerable tributary population. Twenty to 25 per cent of practitioners in communities of 50,000 or more restrict themselves to a specialty, whereas in communities of 10,000 or less the proportion is about 3 per cent, and in communities of 5,000 or less, about 2 per cent, which is only further evidence of the tendency of physicians to specialize—a tendency which is three times as great at the present time as formerly.

Physicians Must Cooperate

It is evident that individual specialists doing an isolated practice cannot meet fully the needs of either the individual or the community. It is important that the specialist should be constantly supplemented by cooperation with other physicians, for the best interest of all concerned. It is specialization in the development of technical procedures which has in part made necessary the organization of clinics, hospitals and other devices of coordination, and has introduced into medical practice the elements of team work and management. The individual physician of the future must more and more be willing and able to obtain in special fields the assistance which the patient may require, and the best method of securing the cooperation of specialists is through the hospital.

There can be little doubt that an adequate distribution of hospitals with facilities for proper medical practice would be a considerable factor in aiding the distribution of physicians. The concentration of medical practice in hospitals and clinics or offices is tending to increase consider-

ably the effectiveness of individual physicians. More and more patients are coming to doctors and to hospitals for care instead of the physicians going to the homes. This is partly in response to the growing appreciation on the part of the public of the value of early treatment and of hospitalization for many of the serious illnesses. Hospitals and clinics are likely to continue to grow rapidly in the next decade and will tend to increase further the effective use of the time and energy of the physician, partly through hospital out-patient services, through institutional and visiting nursing and similar activities.

This is an important matter in relation to the probable future number of physicians. The medical schools in this country have been reduced from 166 in 1904, when we possessed one-half of the world's supply, to 69 four-year schools at the present time, only 61 of which are Class A schools. The enrollment of medical students at the present time is one-third less than it was in 1904. This is not as serious as it might appear, because during the period up to 1910 there was an overproduction of physicians, many of whom were inadequately trained in the commercial and proprietary medical schools which were so abundant in the country. We have an adequate number of physicians, but they are poorly distributed, with an unnecessary concentration in the cities.

Average Age of Physicians Is Increasing

Owing to the large overproduction of physicians early in the century, we now have a rapidly increasing average age of physicians, a factor that will become of growing importance in the next fifteen years. In 1910, for example, 39 per cent of all physicians were forty-five years of age or older, whereas in 1925, 61 per cent were of that age. At present there are 129,000 physicians under sixty-five years of age in the United States. It can be predicted that on the basis of the present output of medical schools the corresponding number of physicians in 1945 will be about 114,000.

We are confronted, therefore, with a probable reduction in the number of physicians, in the face of an increasing population and a possible net increase in medical responsibilities. These figures, which have been compiled from life expectancy tables and other pertinent data, have been correlated with the estimated population of the country and it can be said with reasonable accuracy that the population per physician in 1945 will be about 50 per cent greater than at the present time.

This probability suggests that we shall be obliged either to increase the effectiveness of individual practitioners to a considerable extent or

to produce more physicians for medical practice, or both, if we are to retain a ratio of one physician to approximately eleven hundred of the population, probably somewhere near the desirable ratio. At the present time the ratio is one physician sixty-five years of age or younger to 890 of the population.

These figures do not take into consideration the great increase in irregular practitioners, who now in many communities represent 20 per cent of all the practitioners of the healing art. These predictions are mentioned only to indicate the probable necessity of increasing the individual effectiveness of medical practitioners and of securing a better distribution in the smaller communities. There is a growing opinion that the most effective method of securing this distribution and gaining the advantages of specialized practice is through the hospital which is properly equipped and prepared to deal with all medical needs of a given community.

These various suggestions are made with a clear recognition of the added cost that will be involved. It is true that a considerable fraction of the increase in cost of medical service has come through the greater use of specialists—a use which, in certain instances, at least, has actually been detrimental—but it seems inevitable in the complex field of medical practice that a division of labor is not only necessary but desirable, provided it can be kept within reasonable bounds. One of the important factors in stabilizing medical practice within such reasonable bounds is the general hospital, and it is more than likely that communities would be not only willing but able to devise ways and means for supporting adequate hospital services. Such hospital centers would in turn serve as nuclei for medical and nursing practice. In the long run there could be little doubt that such a program would amply repay the community in a type of medical and nursing service that could not be measured in terms of money alone, and would bring about an even greater correlation between the hospital program and the health needs of the community.

DO NOT LEGISLATE HASTILY

"The entire question of hospital support is involved in the much larger one of the economic value of health to the citizen and the community," says the *Hospital, Medical and Nursing World*, speaking editorially on the bill respecting hospitals recently introduced in the Ontario Legislature. "But until this larger outlook and its ideals are realizable it is better that every step in hospital legislation should be taken only after full consideration and discussion of all aspects and bearings on the matter, by experts in this phase of public work."

A HOSPITAL ADMINISTRATOR LOOKS AT THE VISITING STAFF

By Joseph C. Doane, M.D., Medical Director, Philadelphia General Hospital,
Philadelphia

FROM the superintendent's office window a familiar picture daily presents itself. It is a moving picture. Its actors are the members of the institution's visiting staff. The manner of their goings and comings seems to him somewhat characteristic of their personalities and their professional habits.

The administrator notes the daily arrival of the methodical visiting chief, whose hour for his hospital visit during the past decade has been so regular that the executive could almost set his watch by it. The superintendent mentally compares the orderly arrival and departure of this type, whose intern is always waiting at the door and whose ward service is ever scientifically immaculate, with that of the younger staff member who, bustling out of his car, is seen rushing up the hospital's front steps. This physician also regularly visits his patients, that is, on each day of the week, but his hour of arrival ranges from seven-thirty in the morning to nine-thirty in the evening. Meal hours are often the times selected for his ward rounds, and much difficulty is experienced by the supervising nurse

in promptly locating the bewildered intern, who is torn between duty and the pangs of an intellectual hunger, and the demands of a hunger more physical but no less urgent.

The executive notes the dignified disembarkment of the medical gentleman of the old school, from a car not so garish in design and finish and

perhaps less expensive than that of the more recent medical graduate who, rumor whispers, is fast becoming wealthy. He surmises that perhaps the courteous, apparently leisurely greeting that the former gives the hospital's doorman is an individual trait, and yet he wonders whether

in the quest for many dollars with which to meet rising office and garage rents and satisfy the financial demands of present day life, the new school has not lost some of the charm that the older generation of physicians possessed.

But now a third type arrives. The observant executive notes his nervous almost irascible exit from his car—barely have its wheels ceased turning before its occupant is making his way into the hospital. The surgical wards are on the qui vive, for 'tis he, the skilled, successful but hard to please chief of the surgical staff! Bells jingle; nurses stand at almost military attention; the intern slyly finishes masticating his breakfast toast. All wonder upon whose defenseless head will fall the not always undeserved bludgeon of censure for "leaving undone the things that

Then and Now

TOMORROW there will stop in front of thousands of hospital doors a great fleet of automobiles of all sizes and sorts. From these cars there will alight an army of kindly, scientific physicians in whose hands and hearts are the lives of those stricken with disease, who await their coming with expectation and anxiety, just beyond the institutional doors.

Gone are the top hat and frock coat, the horse and carriage of the physician of yesterday. The business suit and the automobile have replaced them. Does the old time doctor compare unfavorably with this newer product of our medical colleges? Does the waiting patient stand a better chance of recovery as a result of the ministrations of the modern medical scientist than he did under the care of the physician of half a century ago? Certainly the physician of long ago does not suffer by comparison in regard to the qualities of the heart, for in the hearts of the men of medicine of long ago and of today can be found the same love of their fellow men, the same anxiety and fearlessness to know the truth, the same devotion to ethical right and wrong, as each is given to see it.

ought to have been done," which may be numerous.

Of this type it has been said that the hospital can neither get along with or without its representatives. The superintendent wonders why the peripheral nerves of skilled surgeons appear to have no surface covering, are raw and easily irritated. Perhaps it is the result of long

hours spent in the high tension atmosphere of operating rooms, perhaps the continual threat of operative catastrophe under which this physician exists. Perhaps the touch of the musician, the temperament of a leading man, are necessary for the development of exceptional surgical ability. Certainly, coupled with these qualities and leavening the whole, are often to be found a self-forgetfulness, a consecration to duty, a nature of such fineness that all else is forgotten in admiration of the humanity of these men.

While but a half-hour has passed since the first arrival, a roaring motor announces that the hurried young physician has completed his rounds and is departing for greener professional pastures.

Let Us View the Administrator

But the administrator who has been thus meditating on the varied personalities that comprise the hospital's staff, has himself been observed.

He often appears to those professional gentlemen passing his doors, as something of a necessary evil, something of a mixed blessing with a tendency to originate and require obedience to rules that to the scientific mind may appear trivial or even meddlesome. His desk looks too orderly to suggest pressure of work. Apparently he rarely extends himself either physically or mentally. While he chats with the busy surgeon on some institutional matter, one seems to sense an attitude of embarrassment in the former, or is it distrust or abstraction in the latter? It appears to be the feeling which some semi-rebellious boy might have for his teacher who had been forced to reprimand him. Perhaps this unnatural attitude is but the outward evidence of a certain class distinction, of the time-old line of cleavage that has divided the lay from the medical.

The superintendent, if a physician, sometimes seems to sense a sort of pitying attitude in members of his hospital staff, the commiseration of one who knows about human hearts and livers for one who once understood, but who has so fallen from his high estate as to barter for those of bovine extraction.

Have you often seen the chief of staff matching drives on the golf course with the hospital superintendent? More likely you have observed the treasurer or the president of the board of trustees so engaged. Perhaps this lack of social intercourse between hospital executive and physician is simply explained by the professional demands on the time of the latter; perhaps by the fact that few superintendents capture golf cups in club tournaments.

But while the hospital superintendent is always

at hand when things go awry and is the target for oftentimes real but sometimes unfounded complaints, he must tread carefully lest he offend should he deem a mild staff reprimand necessary. His well meant and infrequent faultfinding with staff members, sometimes appears to them officious, uncalled for, unwarranted. Nor is this because the Æsculapian mantle rests too heavily on the staff shoulders. The hospital is the doctor's workshop, and if tools are dull or misplaced, someone must be to blame, and that someone is logically the superintendent.

To the physician, the superintendent is the keeper of funds of unknown but probably ample proportions. The staff often does not know whether last month's coal bill has been met or not. But these demands for the gratification of a new scientific urge by the purchase of expensive scientific instruments, while just and desirable, often are embarrassing to the superintendent who knows of the impoverished condition of the hospital's treasury. Experienced executives have learned to expect such requests at the conclusion of the American Medical Association meeting or meetings of a similar nature. Then, the fires of scientific zeal burn brightest and fortunate is the executive who can fan their flame into a heat from which may emerge the purified gold of some new discovery as to the cause and effect of disease. Mayhap the conscientious administrator is importuned to buy some interesting but expensive apparatus for which the ultrascientific member of his staff yearns, but the purchase of which financial limitations make impossible. This situation demands tact and firmness if the terms "unsympathetic, penurious, autocratic" are to be avoided. The determination of the total quantity of a patient's perspiration, or the opportunity for each member of a large class to hear simultaneously the heart beat, are, without doubt, scientifically important, but the need for coal and food and x-ray plates appears even more basic though less picturesque.

Choose Staff for Ability

But no hospital can review its assets without prominently placing on this list a skilled, faithful visiting staff, whose members have been chosen largely because of their ability instead of their wealth or social or political standing. Good hospital "feeders" on the staff, whose clientele have been attracted to them because of their professional excellence, are necessary. The hospital must keep its private rooms well filled to meet successfully the rising cost of conducting its work. But in meeting these current obligations and in raising funds for expansion, the staff is often

covertly, if not actually, unfairly required to contribute money. It is neither ethical nor just for staff members, unless by their request or acquiescence, to be importuned to contribute in these drives.

And yet, as long as group effort is directed toward the consummation of some one objective, there will be individuals whose personality, material or spiritual gifts mark them as leaders. In the hospital field are found many such characters whose influence overshadows that of others round about them. Sometimes it is a strong personality on the board of trustees; again, a staff surgeon or physician dominates every phase of the hospital's work. This influence may be as often harmful as beneficial to the hospital's effort to serve its community.

The physician whose prestige or personality secures for him new instruments and always new gloves when his less fortunate but equally skilled colleague uses repaired apparatus and gloves that are patched, is not always the cause of high staff morale. And yet, have you noticed the anesthetic effect which an easy-going staff personality has on the service that he receives from nurses and resident physicians? Verily, irascibility sometimes has its immediate reward.

Administrative Absent-Mindedness

Hospital association programs and institutional publications teem with exhortations and arguments as to the reasons for better education for hospital superintendents. It is feared that some visiting staffs are not always informed as to the most elementary and fundamental laws of administration. To allow disobedience to an institutional rule, or, what is worse, to urge such an infraction of discipline, may do much harm. "Surely, if the distinguished physician winks at rule breaking," argues the intern or nurse, "we need have little regard for such 'scraps of paper.'" And often this attitude is but the result of lack of knowledge, of thoughtlessness or of the presence of what, for want of a better term, may be called "administrative absent-mindedness."

To be concrete, smoking in the hospital corridors is not a crime, nor is the burning of one cigarette likely to be highly offensive or detrimental to the health of sick people. But interns, assistants and ere long, nurses, I fear, will demand the privilege that has been claimed by the chief surgeon.

Again, this lack of hospital-mindedness is often manifested by the physician's acceptance or promise of admission of patients who are later found to live in a district that has no claim on the institution's benevolence. The superintendent,

to uphold the visiting physician's standing, must accept such a patient, even though his hospital loses thereby.

Of more frequent occurrence but of less magnitude are the losses that the physician could largely prevent if he possessed or employed this same quality—hospital-mindedness. To waste catgut, gauze, glass syringes, rubber tubing or biological products, is easy and each instance is trivial, but the example set, as well as the aggregate loss, is capable of working much hardship on both the institution's morale and its budget.

Rules Should Be Observed

Again, the attitude of otherwise conscientious physicians relative to rules covering preoperative preparation or the wearing of gowns in infected areas, is difficult to understand. Perhaps it is merely the instinctive and momentary resentment of modern life against any restrictive or prohibitive legislation of whatever sort or source. It is not sufficient for the surgeon to accept complete responsibility for the breaking or circumventing of an accepted and meritorious rule. In the last analysis, the board of trustees rules and holds itself accountable for the results of this legislation. The surgeon cannot change such rules at will. A distinction is here drawn between variations in scientific technique and the observation of hospital departmental rules.

But what of the doctor's return for his services to the hospital's patients? Does he have an obligation to the patient whose finances barely permit him to occupy an expensive private room, but who is able and willing to meet not only the hospital's expense for less costly accommodations, but also to reimburse, in a moderate way, his physician? The physician will gladly treat such patients in the general ward. If he does this, however, in a goodly number of hospitals he may receive no fee for his services, even if the patient is willing and able to pay a moderate amount. What is the criterion upon which the hospital should determine the doctor's right to receive a professional fee? Should it be the location of the patient in the hospital, or would it not be more reasonable to set the ability of the patient to meet the expense to which the hospital has been put for his care, as the deciding factor in the matter?

'Tis true that from time immemorial, the free care of the ward patient has been the fee that the doctor has paid for the privilege of treating his more opulent patients on the private floors. The practical application of the workmen's compensation act has again opened up, and rightfully so, the whole question of the doctor's fee and the ward patient.

Of all the by-products of the hospital's activity, the educational phase is perhaps the most important. On a day late in October, 1884, a man alighted from a street car near the hospital of the University of Pennsylvania, Philadelphia. He is said to have presented a somewhat unusual appearance for staid old Philadelphia of four decades ago, with his frock coat, top hat and red flowing necktie. He carried two packages, one of which contained books and papers and the other, his lunch. Thus came to this old school a teacher who was destined to leave an impression there that remains even to this day. This man was Dr. William Osler—W. O. as he cryptically signed his more informal communications.

Doctor Osler brought to his school and its hospital the principle that medical teaching, to develop its full force, must be done with patients to illustrate the disease being discussed. Each of his visits to the hospital became a ward class for the resident physicians there, and they were eagerly awaited by these young men. He would sit for hours poring over a pathological specimen, searching for the opening of a ruptured blood vessel, for example, which resulted in a pulmonary hemorrhage, or for the point of bleeding in an esophageal varix. It is related that on a certain Sunday afternoon he canvassed the whole hospital to gather all the interns together so that he might demonstrate a chest full of fluid which he had declared, *ante mortem*, to be a consolidation.

Relationship of Intern and Chief

Now, I think it can be asserted without contradiction that no period in the educational life of the young doctor so certainly determines the manner and methods of his future practice as does his hospital internship. If this be so, the future of American medicine is in the hands of the staff physicians of our hospitals. We must, of course, maintain high scholastic standings in the medical schools, but the hospital intern has so indelibly imprinted on his mind the methods employed by his chief in treating his patients in the hospital, that he remembers these long after he has forgotten a brilliant didactic dissertation.

It is difficult to discuss this relationship of chief and intern without reviving some of those care-free hospital days which were so little appreciated at the time, but to which all physicians later look back with a feeling akin to longing.

In a certain hospital there was one visiting physician of whom all were fond. His appearance at the door of the ward was always a sartorial triumph. With a tie vying with the rainbow in color, pearl spats and clothes in which

there never was a wrinkle, he would walk arm in arm with his intern down the center of the ward, as a general might review his troops, and then on the return trip stop here and there to examine a patient with the intern or to advise treatment. How the intern enjoyed for a few brief moments stepping up on the pedestal beside this wise and kindly man, being made his equal, his associate, his colleague. Thus did he learn that the medical fellowship is a guild of which he must strive to be a worthy member.

It matters little whether the hospital possesses one or a hundred interns. If the members of the visiting staff go about their business of restoring human usefulness, without, in so doing, preparing others of the younger generation to carry on this work, they are failing miserably in grasping an opportunity for service to humanity. Moreover the hospital that possesses such a staff, is likely—very likely—to become grooved, to lag in scientific advancement, to retrograde in the public's confidence.

Doctor as Humanitarian

No one can speak with more authority than the hospital administrator, unless it be the ward patient, on the subject of the doctor as a humanitarian in hospital work. There is no finer example of self-sacrifice, of the elevation of service, and the submersion of self than is exhibited by the average visiting physician and surgeon in our hospitals.

Tomorrow there will stop in front of thousands of hospital doors a great fleet of automobiles of all sizes and sorts. From these cars there will alight an army of kindly, scientific physicians in whose hands and hearts are the lives of those stricken with disease, who await their coming with expectation and anxiety, just beyond the institutional doors.

Gone are the top hat and frock coat, the horse and carriage of the physician of yesterday. The business suit and the automobile have replaced them. Does the old time doctor compare unfavorably with this newer product of our medical colleges? Does the waiting patient stand a better chance of recovery as a result of the ministrations of the modern medical scientist than he did under the care of the physician of half a century ago? To be sure, the former has his insulin, his Dick test and serum, his antitoxin and many other modern weapons against disease. Nevertheless, it is doubtful whether there has been a proportionate advance in the methods of physical diagnosis, in the art of securing information by laying hands on the patient, by listening to his heart beat, his respirations.

STUDIES ON HOSPITAL PROCEDURES

DUE CARE OF THE HOSPITAL PATIENT —A LEGAL DEFINITION

WE ARE accustomed to consider the hospital in relation to our own professional interests and activities, what we think should or should not be done. Sometimes through force of personality or circumstance we can accomplish our objective. Tradition and law have given a definite social and legal status to the institution on which legal responsibilities and exemptions are based, and the day's work and the activities of each employee are the interpretations and assignments of these functions and activities.

The hospital is defined legally as a place for the care of the sick. It may be public or private, incorporated or unincorporated, charitable or proprietary in character.

The distinction between the public and private, the charitable and proprietary institution is fundamental and constant. The public institution has certain exemptions at law, for example the state does not tax itself consequently public hospitals pay no taxes. The state is not liable for the torts (the aggressions or mistakes) of its agents, hence the hospital enjoys this exemption with certain modifications. This is not true of the private proprietary institution which has the responsibilities of all businesses in matters of taxation and negligence.

To what extent is the hospital responsible for the acts of its agents? Is it responsible? Where can such responsibility be placed? What of the patient under such circumstances? The cases which have come to the courts in the last year have shown rather interesting developments.

Exemption of Public Hospital

The public hospital enjoys the exemption of the state from suit, following the theory that the state can do no wrong. A New York case which involved the university in a laboratory explosion considers the matter of exemption, the administrative plan, the selection of servants and the assignment of duty: "The rule is settled

in this state and generally elsewhere, that a hospital, if public or charitable is not liable for the negligence of its surgeons or physicians in the treatment of its patients. A patient resorting to a hospital gains the benefit of facilities that would not otherwise be available. If these are furnished, he has no other remedy for the errors of surgeons or physicians, carefully selected, who have given him treatment in a ward, than he would have if the same men, upon the recommendation of the hospital, had given him treatment at his home. By fair implication he must look to them alone. . . . There is indeed a duty to select them with due care. That duty fulfilled, there is none to supervise day by day the details of their (work.) . . . There is no suggestion in the evidence that the method here in vogue was ineffective in its normal operation or faulty in design.

Origin of Negligence

"The negligence, if any, had its origin, not in defects of plan or system, but in mistake or inattention in the doing or the omitting of something that was a detail of the work. . . . What controls is the relation of the act or omission to the proper function . . . and the work appropriate thereto. The instructor, who fills bottles in the laboratory or the auxiliary storeroom in making ready for assigned experiments to be presently conducted, is acting no less as an instructor than if he were doing the same thing in the course of a lecture or demonstration. . . ."

"There is no evidence that the instructor or employee had been carelessly selected. The burden of proof is upon the defendant . . . (nor) that the administrative employees were incompetent when the qualifications are measured by the nature of the tasks assigned to them; nor any evidence that their incompetence, if it were proved, had a causal relation to the accident and the injuries. . . . The work did not involve the smallest element of expert knowledge or discretion. There is nothing to suggest that either of them was lacking in the requisite intelligence of acts so simple and perfunctory."¹

The question is raised in the Young case as to whether the plea of gross negligence can be entered to take a case out of the field covered by the negligence decisions which exempt certain institutions from liability. The court agrees that there might be degrees of negligence, but "the principle which exempts municipalities from responsibilities for injuries received in consequence of a negligent or defective performance of a public service is of equal pertinency whether the negligent act is greater or less in culpability than is ordinarily imputed to negligent conduct," in

¹A study by the editorial board of THE MODERN HOSPITAL and Dorothy Ketcham, Ann Arbor, Mich.

other words, there may be a distinction in degree, but this does not mean a difference in kind.²

An insane patient died in a Kentucky state hospital. The authorities tried to locate the wife but were unable to do so and notified the county court of the patient's residence. The court was unable to locate the wife although the postal authorities and the hospital had been notified of her change of address. The body was shipped to the University of Louisville, Louisville, Ky., and eventually after much confusion was claimed by the family who demanded damages from the state hospital and the university. The court remarks: "It is sufficient to say that an asylum, or as it is now called, a hospital, created and maintained at the expense of the state for the care of the insane, is a mere instrumentality of the state government brought into being to aid in the performance of a governmental duty, and is not therefore liable in damages for either the negligent or malicious acts of its officers, agents, or employees. . . ."

"The only exception to this rule is where the institution commits a nuisance and thereby injures the property of another or otherwise takes and injures the property of another without making just compensation therefor. This case does not fall within the exception, for whatever may be the nature and extent of one's property right in a corpse, it is not the kind of property that may be condemned, and is not therefore protected by the constitution. Nor is there any merit in the contention that the hospital authorities were not performing a governmental duty in sending a corpse to the University of Louisville, because they were not then engaged in the care of the insane, but were acting under a statute regulating the disposition of unclaimed bodies. The disposition of the unclaimed bodies of the insane is as much a governmental function as their care and maintenance during their lives, and when the superintendent of a hospital acts under the statute he simply performs a duty imposed on him as the agent of the hospital, and the hospital in acting through him acts as an arm of the government and not in a private capacity."³

Employees' Negligence

The private charitable hospital enjoys, as we have said, many of the exemptions of the governmental unit. A public charitable hospital, which on the arrival of a patient, agreed to keep and return her jewelry has been held not liable for the wrongful delivery of this property to an imposter who represented himself to be her son-in-law.⁶

"Under the theory of non-liability of charitable institutions adopted by this court, as heretofore indicated, we are unable to make any distinction

between cases involving damages to the person of a patient and damages to his property, where such are caused by the wrongful act of an employee."⁶ The court points out that a public charitable hospital is not liable in tort for injuries to a patient resulting from the negligence of one of its employees where reasonable care is used in the selection thereof. This patient was brought in as an accident case having been struck by a street car. A policeman brought her in a taxicab and the hospital agreed to keep her valuable jewelry and return it to her.

The California court has held that no action can be maintained against an insurance company on a policy insuring a hospital from liability for damages until final judgment is recovered against the assured, where the policy so provides.⁷

Evidence of Negligence

The jury is the fact finding body legally. To this body the court explains the law. The court itself does not ascertain matters of fact, these must be presented by the contestants except that the court may take cognizance of matters universally known. The Supreme Court passes upon matters of law such as: Was the evidence sufficient? Should it have been admitted? Were the damages awarded reasonable or unreasonable? If the Supreme Court upholds the judgment of the inferior court such judgment is enforceable. If the judgment of the lower court is reversed then the case may be remanded (sent back) for further trial. The following cases indicate the evidence which is necessary to prove negligence, the failure to present a case because the evidence was ruled out, and the pertinency of evidence. The difficulty which arises comes from the fact that evidence or statements satisfactory to the hospital or the physician do not, of necessity, satisfy the court, which sees the situation more objectively. That factor which determines the hospital decision may never even appear in court.

An action was brought to recover damages alleged to have been received in the private hospital of the defendant, and alleged to have been caused by the negligence of the nurse. The defendant conducted a private hospital for the care of medical and surgical cases (charitable or proprietary character not noted). "Various physicians in no way connected with the hospital sent patients there, and had full charge and control of their patients, their diet, care, surgical operations, and the exclusive direction and control of the defendant's hospital nurses who attended such patients, the services of the nurses being paid for by the defendant." The patient was sent to the hospital by a Dr. Gately who employed a Dr.

Walker to perform a gall bladder operation. Neither of the physicians had any connection with the hospital. Three days after the operation an abscess formed in the right thigh of the plaintiff at a place where injections of pituitrin had been made. The patient claimed that the abscess was caused by an injection given in haste and with faulty method.

Dr. Walker testified that while he did not recall giving instructions to the nurse to give injections of pituitrin if gas developed, that he might have done so. "No contention was made that it was not a proper remedy to be administered if proper precautions were taken to prevent infection. There was evidence that before the needle is inserted the skin should be cleaned and some suitable antiseptic applied. The question is whether there is any evidence warranting a finding of negligence if it be assumed that the defendant is responsible for the carelessness of the nurse in administering the injection. The defendant offered evidence tending to show that the room was well lighted, that the injection was not hurriedly made, and that the place where the needle was inserted was properly sterilized, and that the injection in all respects was properly administered."^s

Insufficient Evidence

The evidence is considered by the court insufficient to warrant a finding of negligence. "There was no evidence that the hypodermic needle used was infected, or that the abscess was due to an infection. Dr. Walker, who was called by the plaintiff, testified that he did not know what caused the abscess; that if the skin had not been properly washed he could not say that it was the cause, but that it might be the cause. He further testified that he would not go so far as to say that the abscess was probably caused by failure to wash the skin, that it might have been caused by the condition of the skin of the patient, or the solution injected might have been unsterile when it came from the manufacturer. He testified in cross-examination that if the needle was properly sterilized, but the place where it was inserted was not washed or cleaned, it would not necessarily lead him to believe that an abscess would form. . . .

"There was other evidence offered by the plaintiff tending to show that she had jaundice and diabetes, and that an abscess would be more likely to develop if a person were suffering from the latter disease. Although several physicians testified, none of them were able to express an opinion as to what caused the abscess. In these circumstances there was nothing to show that any act

or omission of the nurse resulted in the formation of the abscess. Its cause was wholly a matter of conjecture and speculation without evidence to support the finding of negligence on the part of the nurse."^s

Admissibility of Evidence

The following letter was admitted in evidence (in a hospital burn case) over the defendant's objection. The plaintiff was born at the defendant hospital and a few hours after birth received the burn which was the basis for suit. A letter was written by the defendant president to the mother of the plaintiff: "Dear Mrs. Jones: We are enclosing a statement for your hospital expenses for the first two weeks. This amount would have been due if the child had not been burned. We shall appreciate your remittance to cover and the balance can be cared for after the case is settled." This letter and statement of the hospital in the opinion of the court was not material on the question of the liability of the hospital.⁹

Only the most unusual or exaggerated situation comes into court and such contingency is usually avoided by amiable settlement. Our industrial or compensation and employers' liability experience has shown that the weaker and more ignorant party to suit does not always present his case well, nor is he overburdened with the swiftness of justice and equity. In the case of workmen's compensation particularly, as in certain other fields, the injured workman presents his case informally to a fact finding body which decides according to the statute the rights covered. This reduces the expense and hastens the decision. The worker is the weaker party in an argument in industry, the patient the weaker party in an argument with the hospital. It is true that some industrial leaders and interests have given great assistance and consideration to their workmen; so have some hospitals.

The succeeding situations raise some interesting questions. What is the law of the hospital not in the unusual but in the usual day by day routine with patients, with personnel and with professions? We see a multiplicity of petty courts with little correlation of principle and rules, far too dependent on the equity of one individual, with powers and responsibilities of an autocratic government, almost without appeal or a day in court. The hospital is no longer an individual concern, it is a community affair. The thousands of people who pass through the medical institutions of the country in a day are as a rule entering strange territory and are entirely dependent on the routines of those institutions for adequate defense. Can the necessarily concomitant difficulties be so

mechanized and made available for correlation as to insure increased understanding for the patient as well as the professional group?

There was an action in tort to "recover damages for the conscious suffering and death of the plaintiff's intestate, alleged to have been caused by the negligent medical care and treatment of the defendant's servants and agents while she was a patient, or by the negligent administration of certain drugs and medicines."¹⁰ The question before the court was whether as a matter of law the defendant was a public charity, consequently exempt from liability. The institution was organized under "an act concerning associations for religious, charitable, and educational and other purposes." The charter, dated November 10, 1880, states that the corporation is formed "for the purpose of establishing and maintaining a college for the prosecution and promotion of educational, scientific and medical purposes." The defendant was also authorized and empowered to confer the degree of doctor of medicine.

"The charter, however, did not of itself make the defendant a public charity. The controlling purpose must be for the common and public benefit, and if it was created by the incorporators, or thereafter was administered and maintained by their successors for money making, this essential element is lacking even if it may at times have expended money for purposes, or rendered gratuitous services which in common speech are called charitable. . . ."¹⁰

The testimony "tended to show free tuition for students in some instances, and the free treatment in all instances of patients in the college and the dispensary."¹⁰ The court held that the jury might accept or reject in whole or in part the evidence of any witness even if uncontradicted by any evidence offered by the plaintiff and could decide that although there was evidence that the institution was a public charity, that the college in fact was primarily conducted for private ends.¹⁰

The two following cases involving hot water bottle burns arose on legal technicalities, first, the sufficiency of a question for the jury and second, the so-called limiting of liability by the posting of notices.

Employment of Probationer

Harry Tribble, for the consideration paid by him, became a patient at the Columbus Sanatorium, a hospital operated by the Missionary Sisters of the Sacred Heart. After an operation in the surgery while still under the influence of an anesthetic, he was taken to his room and placed in bed. His attendant or attendants neglected to remove an aluminum bottle of hot water that had

been placed in the bed, and which in a short time severely burned and injured him. He sued the defendant, alleging negligence in its care of him and negligence in the selection and retention of the person assigned to take care of him. It seems that the hospital trained student nurses and that about the time the patient regained consciousness, a probationer discovered the bottle of hot water which had been left in the bed, and, on taking it out, exclaimed that she had forgotten to take it out. . . .

The fact that a hospital receives or exacts compensation from those desiring its privileges, to the extent of their ability to pay, does not necessarily deprive the hospital of its charitable character. A charitable institution or hospital is liable for injuries arising from the negligence of its officers and managers if it fails to exercise due care in the selection of servants. "Ordinary care in the selection of servants implies and demands that degree of diligence and precaution which the exigencies of the particular service reasonably require. Admitting the purpose and advisability of using one or more bottles of hot water to increase the lowered circulation of a patient, due to an operation, it is nevertheless highly important that a bottle of hot water capable of doing harm should not be left in such position in bed that a patient may be injured by it. The situation requires more care if the patient is unconscious."¹¹ The negligence of the hospital in employing a probationer is for the jury under evidence.

The Proprietary Hospital

In the second situation, the plaintiff, a minor, started an action to recover damages for burns inflicted on his leg while he was a patient in the hospital. Damages were awarded.¹²

"The law imposed on the defendant (the hospital against whom damages were awarded), the burden of introducing evidence to show that said individuals (certain nurses), and especially the two last named, were not its agents, and that the defendant was not guilty of negligence. It wholly failed to sustain that burden. . . . There was evidence that the appellant (the hospital) has posted in different places in its premises certain notices limiting its liability. There is no evidence that the plaintiff or his parents saw or read the notices or entered into any contract limiting the liability of the appellant. The appellant does not call to our attention any statute which authorizes a hospital to limit its liability by posting notices. The trial court did not err in refusing to admit the contents of the notices in evidence."¹²

The following situations involve the care of the insane patient where reasonable care and precau-

tion are necessary. What is reasonable care?

Damages were awarded the wife and daughter of Claude T. Deaderick sustained by him through the negligence of the sanatorium in permitting him to escape from the sanatorium where he was confined for mental derangement.¹³

Following influenza Mr. Deaderick was so nervous and disturbed that his wife took him to the sanatorium, "an institution conducted for the purpose of treating persons with mental diseases and nervous disorders," had him examined and placed in charge of the sanatorium. She requested a special nurse but was informed that a nurse would not be needed. She agreed to pay fifty dollars per week which was later reduced to forty dollars. Early in the morning of November 25, 1920, Mr. Deaderick escaped from the sanatorium "at a time when he was walking around the building without restraint and without any one to watch over him and prevent him from leaving." He wandered into the city of Fort Worth and about 7 p. m. the night watchman found his dismembered body, on a railroad track.¹³

Negligence Shown

The superintendent of the sanatorium knew that Mr. Deaderick was shrewd and cunning and might escape and hurt himself. The room in which he was confined had no lock and could not be well fastened. No one was watching Mr. Deaderick when he left the building. The court concludes that the jury was justified "in finding that appellant was negligent in permitting his escape, and in not discovering and returning him to the sanatorium before he was killed on the railroad tracks. . . . If he had not been permitted to escape, he could not have gone to the railroad yards, and if he had not gone to the railroad yards he would not have been killed. . . ."

"When a patient is placed in a sanatorium, suffering with mental trouble, it is the duty of the officers and employees to use ordinary care in watching, caring for, and treating him, and such duty is not performed if the patient is negligently permitted to escape, and the guilty party will be liable for all damages proximately arising from such negligence. . . . The negligence in permitting the deceased to leave the sanatorium was a distinct wrong, and appellant was liable for all injurious consequences resulting from such wrong." . . . "If they knew in the sanatorium that deceased had suicidal tendencies or a desire to escape and still accepted him, it was their duty to guard against his propensities and desires."¹³

The managers of a sanatorium operated for profit, who knew that a patient had suicidal tendency were required to use reasonable care to safe-

guard her from injuring herself by reason of such tendency. The defendants, physicians, are co-partners who own, operate and conduct a private sanatorium for gain in Kansas City, Mo., employing nurses and other servants for the treatment and care of patients accepted and received for nervous, mental and other kindred ailments. This woman had shown suicidal tendencies for some time prior to admission and was put in the mental ward of the institution. After two months she returned home for a short time, but attempted to grab a bottle of veronal tablets and was returned to the hospital and again placed in the mental ward for a month. She was nervous and depressed most of the time so that it was necessary to administer opiates daily. "About 11 p.m., on September 11, Mrs. Smith was worrying about her contemplated return to her home. This fact is testified to by defendants, witness, Mrs. Pearson, an employee of the sanatorium, who described the last conversation anyone had with Mrs. Smith, so far as shown by the record."¹⁴

The details of the situation will not be stated. Mrs. Smith was found to have committed suicide. Mrs. Pearson's report read, "Mrs. Smith rested well, and was in a very happy mood when she retired. Was up at 11 p.m. to the toilet. Said she could hardly wait for Friday to arrive, the day she was to go home; looked in the room at 2:30 a.m., and she was sleeping at 4:30 good; at 6:15 found her hanging by neck in corner of room. Called Estes." . . . "the crux of the negligence charge is that defendants failed to use ordinary care to watch Mrs. Smith, and thereby prevent her self-destruction, by reason of her alleged nervous and mental derangement. There is substantial evidence that defendants knew of her suicidal tendency."¹⁴

Safeguard Patient from Self-Injury

"There can be no question but that it is the law that defendants were required, not only to use ordinary care in treating the patient for her illness, but that they were required to safeguard her from injuring herself by reason of her suicidal tendency. . . . The law demands reasonable care, such care as a reasonable man would take under the circumstances existing; but no man is required to take measures against a danger which the circumstances as known to him do not suggest as likely to happen. These circumstances include the patient's mental condition and aberrations, and what he is likely to do by reason thereof, and the dangers afforded by his surroundings."¹⁴

"In the following case the appellant came to the clinic complaining of pain, was operated for ap-

pendicitis and for four or five days was kept in a double room of the hospital with another patient. After this he was removed to a single room on the third floor of the building. A special nurse was not provided, but a nurse in general attendance visited his room at intervals of thirty minutes day and night. At about nine o'clock in the morning of the sixth day after the operation Fetzer was found lying on the ground under the window of the third story room which he had occupied, apparently having fallen or jumped from the window. From this fall Fetzer suffered serious injuries, consisting of fractures and the reopening of the incision made at the time of the operation.¹⁵

It is admitted that the patient had been restless for a night or two previous to the accident, but there is a conflict of evidence as to whether he showed any delirium or irrational symptoms at any time prior to the accident.¹⁵

The trial court instructed the jury that "the degree of care and diligence required is measured both by the mental incapacity of the patient and the dangers which the surroundings indicate may befall such patient in view of any peculiar mental traits exhibited by the patient. This is always limited by the unbending rule that no one is required to guard against or take measures to avert that which, under the circumstances, is not likely to happen, or, more accurately, which a reasonably prudent person under the circumstances would not anticipate as likely to happen. These circumstances include the patient's mental condition and aberrations and what he is likely to do by reason thereof.

Contributory Negligence of Injured

"That a patient may be delirious or not in control of his mental faculties is not sufficient to put the defendant, its agents, servants, or employees on their guard to prevent self-inflicted injury. It is only when they have notice of conduct or language on the part of the patient evidencing an hallucination or a purpose to inflict such injuries" the plaintiff can recover. The court upheld these instructions and points out that "the injuries complained of are directly due to the acts of the person suffering the injuries. Under the general rule of law the contributory negligence of the injured person would bar any recovery on his part, or on the part of his representatives. It is only on the theory that the incapacity of the person injured removes his case from the general rule that any recovery can be had . . . to hold hospitals, nurses or physicians responsible for injuries which patients may inflict upon themselves, unless the patients have

given evidences of the probable danger of such infliction of injury, would be a harsh rule indeed."¹⁵

A dissenting judge says that it is "the duty of the defendants, nurses and physicians to anticipate danger. . . . I think the court again erred in placing the burden upon the plaintiff to show suicidal intent. The doctor had been informed of the condition of the plaintiff, and it was his duty to see that he was protected from injuring himself. . . ."¹⁵

Insufficient Evidence of Negligence

A patient was taken to the hospital by his physician in a depressed mental condition. While in the defendant's hospital where patients are treated for mental and nervous diseases, for private gain, the patient committed suicide by hanging himself with a rope. A letter written by the doctor in charge of the hospital after the death of the deceased was held to be inadmissible as evidence in an action for damages for death. Without this letter the court held that the case was insufficient to go to the jury.¹⁶

"There can be no question about the liability of a privately owned or corporate hospital for individual gain and not for charitable purposes, for damages to its patients resulting from negligence attributable to the agents of such hospital. Ordinarily, when a hospital like the present one undertakes to treat a patient without any special arrangement or agreement, its engagement implies three things: (1) That its physicians, nurses and attendants possess the requisite degree of learning, skill, and ability necessary to the practice of their profession, and which others similarly situated ordinarily possess; (2) that its physicians, nurses, and attendants will exercise reasonable and ordinary care and diligence in the use of their skill and in the application of their knowledge to the patient's case; and (3) that its physicians, nurses and attendants will exert their best judgment in the treatment and care of the case and in the application of this general principle, such hospitals have been held liable for the negligent failure of their officers or employees to guard and restrain insane or delirious patients and prevent them from doing injury to themselves . . . the plaintiff has offered no sufficient evidence of the defendant's negligence."¹⁶

Where a patient was admitted to a hospital for observation and medical treatment only, without any provision for restraint or confinement, after several unsuccessful attempts to commit suicide, and he later disappeared and was found dead, the hospital is not liable under the Death Act (2 Comp. St. 1910 p. 1907) for alleged negligence in permitting escape.¹⁷

"There was no duty of restraint owing from respondents toward appellant's intestate. He was not admitted to the sanatorium under any provision for restraint or confinement as the result of legal proceedings, nor did he voluntarily impose restraint and custody upon himself by his agreement with respondents, but by such agreement he was admitted as a patient for observation and medical treatment only. His death was not the proximate result of any failure of duty owing to him by respondents under this agreement of admission.¹⁷

Note: "Appellant's intestate, her husband, was admitted to respondent's institution on September 16, 1925, for treatment and examination as to his mental condition. He had a tendency to commit suicide, having made two unsuccessful attempts to take his life prior to entering respondent's sanatorium. He remained there until September 25 or 26, when he disappeared, and his dead body was found hanging from a tree in the woods in West Paterson on September 30.¹⁷

It seems then that it is necessary that the suicidal intent of the patient be known to the institution, otherwise contributing negligence becomes a factor and obviates the possibility of damages. The patient must give notice of his condition and the general medical institution receiving such cases has been held not liable when reasonable care is exercised.

Record of Treatment

This action was brought by the plaintiff against the Sulpho-Saline Bath Company, a corporation, and Dr. H. H. Everett, the operating surgeon, to recover damages occasioned by the negligence of the doctor in failing to secure a drainage tube by fastening one end of it to the dressing so as to prevent its slipping into the wound, and to remove the drainage tube before allowing the wound to heal. The result was that the drainage tube, about eleven inches long, composed of rubber, slipped into the wound and remained there and was not discovered by the surgeon and nurses at the time the stitches were taken out, and the wound was closed and healed over with the tube remaining inside.

The case was submitted to the jury, who found in favor of Dr. Everett and against the corporation the sum of \$6,500, and from the judgment rendered thereon the defendant appealed. Four points are raised as grounds for reversal: (1) Sufficiency of evidence; (2) "that the verdict is inconsistent upon the theory that the liability of the corporation depended entirely and exclusively upon the negligence of the operating surgeon; (3) omitted; (4) that the only injuries resulting

were those attributable merely to a proper performance of the operation, namely, adhesions of the intestines and other portions of the abdominal region."¹⁸

The technical details will not be here quoted. The question is whether the hospital could be declared liable.

Evidence of Negligence Was Sufficient

"It appears from the evidence that a daily record is kept of the condition of the patient, and that when a drainage tube is inserted in the wound that fact is reported to the nurse in charge, whose duty it is to enter the fact upon the chart or report; that Dr. Everett instructed the nurse to record the fact of the insertion of the tube, but the nurse failed to make the record, with the result that, when Dr. Olney, the surgical assistant of Dr. Everett, an employee of defendant corporation and the physician in charge of the case after the operation, dressed the wound the following day and subsequently, he received no information from the chart or otherwise that a tube had been inserted, and did not discover its presence, but dressed the wound, and about eight days later removed the stitches, allowing the wound to heal in due course.

"The evidence of negligence on the part of the nurse employed by defendant was sufficient to sustain a finding against the defendant corporation. If the chart had shown the insertion of the tube, Dr. Olney, who testifies that he worked from the chart, would in all probability have noticed its absence and taken proper steps to recover it and place it in proper position to perform its function."¹⁸

A trained nurse, performing her usual duties and exercising the skill which is the result of training in her profession, does not come within the definition of a servant, but rather is one who renders personal services to an employer in the pursuit of an independent calling, and the employer is not liable as master for her acts.¹⁹

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Editorials

CONVENTION TIME

THE time for the convention of the American Hospital Association approaches. An accounting of the work of its officers and committees for the past year is at hand. That its board of trustees has not been idle during the twelve months is attested by the fact that all of its members, save two, have attended the three meetings held at the Chicago home of the association during the year, these two men on only one occasion being absent for no less cause than illness.

Moreover, matters of much importance to the hospital world have been given the most careful consideration by this body. The assembling of an international hospital convention, the question of lowering hospital insurance rates, of securing more equitable compensation laws, are surely subjects that greatly concern hospital practice everywhere.

But THE MODERN HOSPITAL views as a most important step, the move to secure a qualified man or woman as assistant executive secretary, one who will exemplify the desire of the association to render constant, constructive and intimate service to the institutions in the field. It congratulates the association on its wisdom and progressiveness. It is a far cry from Chicago to the shores of California, Oregon, Maine or Florida, and many administrators are not even able to attend, regularly, annual hospital convocations. Enabling hospital executives in remote districts to meet the association's field emissary, its personal representative, and thus making possible the solution with and through him, of vexing local problems, will unquestionably do much to remove all doubt in the minds of administrators everywhere as to the practical value of membership in this association.

But there are many services that the association is not rendering to its members which it might and should perform. Is it throwing its full force into asking—even demanding—in the name of the sick, fair collateral inheritance laws, protection against the ambulance chaser, and adjustment of local compensation injustices in states where they exist? Is the association performing an efficient liaison function between all agencies directly or indirectly interested in the hospital care of the sick? Should not the American Hospital Association take a more active and forward step in de-

veloping the idea that the hospital, to be adequate, must prevent as well as relieve disease?

Why, at its convocations, is the program and place of the trustees' section of such relative insignificance? Can hospitals progress or even long exist without active, informed, medically-minded members on their boards? Is not the time opportune for the development of a suitable and comprehensive code of ethics for hospital practice and should not such a codification of the rules of business and of scientific procedure be originated by this association?

Has the American Hospital Association yet assumed the dignified and influential place in the scientific and institutional world of which it is capable? Does its certificate of membership always denominate a hospital as efficient and trustworthy? Should not this original approval of the American Hospital Association be reaffirmed or withdrawn as a result of other inspections from year to year?

THE MODERN HOSPITAL, from none but friendly, constructive motives, asks these questions. It has a firm faith in the intelligence and devotion to duty of the association's trustees. As time passes, it is hoped that the influence for good, the dignity and prestige of this great association, will be raised to still higher levels.

COMBATING MISINFORMATION WITH FACT

FULL knowledge of facts is the best weapon with which to conquer false rumors, and hospital administrators have been confronted with misstatements in the press and from the platform for some little time, without retaliation.

Those with the best interests of hospitals at heart will always hesitate and consider before they make assertions that might be damaging to the entire field, for the public is quick to grasp the sensational. No matter how ridiculous the statement may seem to those of us who are thoroughly familiar with the facts, the news is accepted as authentic, is spread, distorted, twisted and turned, until a simple statement of a truism such as "Better management in hospitals will mean more efficient hospitals" is soon changed to "All hospitals are badly managed and the public is being ruthlessly robbed by inefficient superintendents who overcharge and waste the proceeds."

It is a matter of record that hospitals are probably better managed as a class than any other business. Costs are high but charges to patients are exceedingly low compared with other expenditures for living and there is less wasting of funds in institutions than in any other business.

With these thoughts in mind an investigation was made by THE MODERN HOSPITAL as to the costs and charges in hospitals and the increases made in both over a period of thirteen years. In the article appearing on page 49, written by Frank E. Chapman and entitled "Holding the Mirror to Our Costs and Charges" are to be found the results of this investigation. Here is the ammunition with which hospital administrators can meet false statements that are made against their own institutions and against hospitals generally throughout the land.

ADVANTAGES OF CONSECUTIVE STATE MEETINGS

A STRIKING development in the hospital field in recent years has been the growth of hospital organizations by states and sections.

It is comparatively few years since the Ohio State Hospital Association was formed, yet since that time nearly every state in the Union and many of the provinces of Canada have formed organizations that meet at least once a year, when state problems as well as national questions are discussed by the administrators of the state or by those who have attained importance in national hospital affairs.

Right thinking hospital executives are agreed that much benefit is to be derived from these organizations. If their only function were the gathering together of the hospital executives once a year for informal discussion, their existence would be justified, but when it is considered that in at least four states the attendance was more than one hundred and fifty and in two cases more than two hundred it may readily be seen that those closest to the situation realize that the time, money and effort expended at these meetings is a worth while investment.

Most state organizations strive to have at least three speakers of national prominence attend their meetings. Often, however, the expense of securing these men is excessive and the men themselves are loath to leave their work for a long journey to attend only a two-day meeting. If the officers of the various states would hold a conference and fix consecutive dates for their meetings, it would be possible to obtain the maximum number of national speakers at a minimum cost.

It costs approximately \$150 to bring a speaker to the Mid West from the East for one meeting, but if five of the states in the Mid West would hold their meetings consecutively the cost per speaker would be considerably reduced and in-

stead of one state paying \$450 for three speakers from the East, they could be secured for all five meetings for approximately that amount, which would prorate to \$90 for each association. Speakers from the West and Mid West could likewise go to the East, and in this fashion the widest possible viewpoints could be secured.

The practicability of this scheme was apparent at the recent meeting of the Western Hospital Association held at Los Angeles, Calif., which closely followed the meeting held by the Tri-State Association in Kansas City, Mo., at which time five well known hospital authorities traveled together from Chicago to Kansas City and then on to the Pacific Coast. In this particular case all five were paying their own way, but it is doubtful if they would have made the long trip if they had not been able to stop at Kansas City for an excellent meeting on their way to the sectional meeting on the Pacific Coast.

Another benefit that would accrue from some prearrangement would be the elimination of conflicting meetings. This year the New York State Association and the Tri-State Association met at about the same time, while the dates of the New England meeting and that of the Hospital Association of the State of Illinois were identical. Had the meetings of Indiana, Michigan, Illinois, Wisconsin and Minnesota been held consecutively, for example in April, and had the meetings of Ohio, Pennsylvania, New Jersey, New York and New England been held consecutively in May, no conflicts would have occurred and it would have been easy to secure any and all speakers desired for all of these meetings, possibly giving them added value and thereby securing a larger attendance for each of them.

TALKING IT OVER

THE best interests of hospital workers are served when they go away from their jobs at least twice during the year—once in order to forget work completely during the annual vacation and again to refurbish their professional equipment and check up their methods with what others in the field are doing. If some hospital executives, when this issue of THE MODERN HOSPITAL reaches them, have decided against a trip to Minneapolis where the American Hospital Association convention is to be held, October 10 to 14, let them give the matter a second and favorable thought.

* * *

EVERYTHING is ready and the stage is set in the 1927 hostess city. Minneapolis is prepared to welcome delegates and hopes they will retain pleasant memories of her hospitality and of a successful convention.

* * *

THERE are three reasons why we should all be there—first, the pleasure of going; second, the obligation to go; third, the real profit to be derived. There is pleasure

in meeting old friends and making new ones and there is value in the change from our daily routine. There is an obligation to support the national association in its efforts to develop the field of our endeavors. And there is profit, for conventions enable men to get the best out of themselves—for themselves and for their fellowmen. It has been said that there is no such thing as an isolated best. A well rounded and vibrant personality is not developed in lonely splendor or cloistered seclusion. No one can do his best alone; it is through our relations to our fellows, through the support we give each other, that we develop the best that is in us. The value of personal contacts, the mingling with others in our line is bound to give us fresh viewpoints on our work, because of the opportunity to exchange ideas on and experiences in meeting common difficulties. In conventions we get that steadying power that is helpful and that will later give us poise and strength when problems vex and perplex.

* * *

IN GENERAL the program this year has been built along much the same lines as previous programs. It will consider, as other conventions have considered, the problems of finance, of legal responsibilities, of food, of out-patient service, of nursing. Those responsible for the program have selected for consideration during the convention those problems that press with greatest urgency for solution. It is for the attending delegates to confront these problems, to weigh them in the light of reason and experience, to pool their several judgments and to achieve not only a plan of action but a strong determination to act in concert. Let us get all there is to be had out of the convention. To get something out of it we must put something into it.

* * *

LAST year many superintendents induced one or more members of their boards of trustees to attend the national gathering at Atlantic City. This was a good idea. It should be seized upon and carried out to the fullest extent. Each superintendent should point out to his trustees that conventions represent an easy method of obtaining information, that they enlarge the horizon, that they bring impulses for progress and improvement. Pass this word about, bring your trustees with you. They need the convention and the convention needs them.

* * *

FROM the cradle to the grave, the active mind of man should be hunting for bedrock, in religion, in ethics, in science and in art, eternally questing a stable base upon which to plant solidly his spiritual and mental feet. Constantly, should we test this philosophy and that, reducing it to its least common denominator, discarding the specious and untrue and cleaving to that which is sound and hence eternal. Perhaps the accumulation of a lifetime of such endeavor may be pitifully small, but if we can face the beyond with even a small handful of truths, we shall have accomplished much.

* * *

CLINICAL records seem to indicate a fondness on the part of the medical profession for abbreviations. T. B., G. C., P. T. N., R. B. C., and similar combinations of letters sprinkle almost every page of the chart. In this connection, one is reminded of the story of the English boy whose father fancied himself very busy and insisted that all letters should be reduced to bare necessities. The boy wrote his father as follows: "S.O.S. L.S.D., R.S.V.P."

If you don't see the point of this story, ask an Englishman what "L.S.D." stands for.

* * *

HOW often do you have a mental house cleaning? It is an amazingly valuable and inspiring thing to go ruthlessly through your brain periodically and to sweep out the dust and cobwebs, to discard worn-out, antiquated and otherwise useless ideas and beliefs, to refurbish and rearrange the mental furniture and then to move in again. It takes courage to admit that your mind needs a spring cleaning, to examine its contents rigorously and to cast into the dustbin aspirations and ideas once dearly cherished, but this very act of taking stock and determining relative values is an exceedingly healthful mental exercise. It promotes a return to the basic in character; it broadens the vision; confirms us anew in useful points of view and frequently encourages the adoption of new angles of sight and simpler, clearer, more direct methods of thought. Given an honest trial, it becomes a habit that builds character and increases usefulness and happiness.

* * *

THERE are three elemental principles that underlie success in the conduct of any piece of work requiring the services of more than one person. They are: organize, deputize and supervise. These are absolutely vital; with any one of these missing the work cannot succeed. At least three legs are required to hold up a table; equally true is it that this tripod is necessary to support any job.

* * *

THE first step in organization is the accurate determination of an objective. Without this, the work may be on its way but nobody knows where it is going. To fix an objective the situation must be carefully estimated as to necessity, obstacles, ways and means. Having done this, the next step is to settle on the lines of power, from executive to subordinate and the coordinate relations with other departments and agencies and the function of each division of the work. A graphic organization chart showing policy and procedure can then be made.

* * *

IT IS a wise executive who knows how to deputize. This demands first of all that he shall control that egotism that drives so many of us to attempt to do all the work—an attempt that seldom succeeds. Equally, it means that he shall resist that laziness that is inherent in all of us and tempts us to deputize too greatly. Next, it requires a keen analysis of the character, knowledge and capabilities of subordinates and an ability to delegate his authority to the person who can use it to the best advantage—the old story of pegs and holes.

* * *

THE foot of the master is the best fertilizer, runs the old saying. This means that supervision makes the work go forward, preventing sloth, correcting inaccuracies and controlling waste of effort and supplies. The closer the executive is to his job, the greater must be the detail of his supervision. He must direct but not nag; he must instruct but not perform the work of others; above all, he must inspire workers in the job and weld them into a cohesive, coordinated team. This is the place where the highest quality of leadership comes in and without it the effort will be bungled. Organization, deputization and supervision—on these three hang all the law of putting the job over.

The Modern Hospital Reading Course: Lesson X

WHY THE SPECIAL HOSPITAL?

By E. H. Lewinski-Corwin, Ph. D., Director, Hospital Information and Service Bureau, United Hospital Fund of New York,
New York

ONLY a little over one-third of our hospital beds are in general hospitals; the remainder are in special hospitals. The number of beds in our hospitals for the mentally sick alone exceeds by 50,000 the bed capacity of our general hospitals, and the remainder of the available hospital resources are given over to the care and treatment of tuberculosis, bone and joint diseases, infectious diseases, child maladies, lying-in conditions, eye, ear, nose and throat affections, skin diseases, nervous disorders and cancer.

As new methods of therapeutics and surgical technique developed, special hospitals were established. At first the general hospitals did not have space, or did not care to provide space for the demands of the continuously evolving and differentiating specialties. Hence, the genesis of special hospitals. Gradually the pendulum began to swing in the other direction until today no general hospital can be regarded as well organized unless it provides staff and adequate ward space and equipment to accommodate the so called specialties.

The question is often raised whether or not encouragement should be given to the further development of special hospitals and, if so, in what direction this development should proceed. Another question of vital importance is the extent to which specialization should be developed within the general hospital organization.

In so far as the special hospitals deal with conditions that cannot be cared for in sufficiently

large numbers by the general hospitals, there is, and always will be, justification for the special institutions. There is likewise no doubt that a special institution often provides opportunities for research superior to the general hospital.

Great strides in certain lines of medical work have been made in special hospitals.

On the other hand, the special hospital suffers from lack of cooperation on the part of men engaged in other fields of medicine, whose observations and contributions are of great value to the specialist in a limited domain.

In other words, the special hospital does not offer as much opportunity for interplay between men of varied interests as exists, or can invariably be made to exist, in a general hospital. It is true that special hospitals have consultants in the several branches of medicine and surgery, but these appointments are merely honorary and the consultants are rarely called in for con-

sultation. At best, this arrangement is but a makeshift, and does not meet the modern essential requirements of team play for the benefit of the patient and team work in medicine.

In a general hospital the ideal of a proper balance between medicine and surgery and the specialties should be striven for. Regard should always be had for the needs of the community rather than for mere academic considerations. Expediency, on the other hand, should not be allowed to sway the situation too far. Because the ophthalmologist or the pediatrician of the hospital has a large following, this alone should

Pro and Con

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not be a justification for the comparative over-development of his department and the allotment of inferior facilities to other departments that happen to be presided over by men of less magnetic personalities or less aggressive acquisitive instincts.

No department of a general hospital should be big enough to swamp its personnel with details of administration and performance so as to preclude their active interest in other branches of the hospital's work. Recently Dr. S. S. Goldwater, director, Mount Sinai Hospital, New York, pointed out this possibility as the chief objection to the huge composite institutions designated in the lingo of the day as "medical centers."* Each of the special services presents a problem of its own. Lack of space permits the consideration of only a few of them.

Tuberculosis Hospitals

Each hospital has a certain number of tuberculous patients, many of whom come for the treatment of some other condition. From an administrative standpoint, however, those with an active pulmonary lesion should be segregated as far as possible, and measures should be taken for protecting the others against possible infection. Some of the large general hospitals have set aside special wards for tuberculosis. In a hospital for acute cases such a service is regarded as of value from the point of view of research, and as a convenient gathering place prior to distribution of the patients in special tuberculosis hospitals or sanatoriums. Some of the municipal or county hospitals have special sections set aside for the more prolonged treatment of tuberculous patients. The bulk of those suffering from tuberculosis are cared for in special institutions.

One of the results of the Framingham, Mass., demonstration was the ascertainment of the need of at least one tuberculosis bed for every death from tuberculosis. This has afforded a measuring rod of the adequacy of hospitalization throughout the country. A table compiled by the research service of the New York Tuberculosis and Health Association, New York, brought out the fact that there were only ten states in the Union that came up to the standard or exceeded it. The remainder of the states fall below the Framingham yardstick. Taking the country as a whole, we are short of 25,864 beds for tuberculous patients. The states that are particularly negligent in providing this type of hospitalization are Alabama, Arkansas, California, Florida, Georgia, Illinois, Iowa, Kentucky, Louisiana, Missouri,

Mississippi, Ohio, Pennsylvania and Virginia.

This is of particular interest in view of the fact that with the decrease in the number of deaths from tuberculosis, the question was raised as to whether further provision for this disease is indicated. The above quoted reference points to the fact that, measured by the Framingham standard of one bed for every death per annum, we are at the present time under-hospitalized to an extent of 25 per cent.

In an able and informing address, Dr. David R. Lyman, Wallingford, Conn., recently discussed the hospitalization program for the tuberculous, and brought out several important points for consideration. He believes that the standard discussed above is inadequate, first, because sanatoriums are becoming more popular as they improve and as the beneficent results of institutional treatment become more generally known. In the second place, physicians are making increasing use of sanatoriums for diagnosis. Thirdly, the average stay of patients in sanatoriums is increasing. Six months is now considered a minimum period for an early case of tuberculosis to remain under a sanatorium régime.* Although few institutions can show such an average stay for their patients, the interesting fact is that the better the medical care and the more favorable the environment, the longer is the average stay of patients.

On the basis of available information it has been ascertained that the average cost of maintaining a patient in a tuberculosis sanatorium is \$1125 a year, or \$21.60 a week. The costs vary greatly, depending on the region, and the type of care given to patients. The highest maintenance cost has been reported from the veterans' hospitals.

Some sanatoriums are inadequately staffed and equipped. In some the patients are required to do a great deal of work, much beyond the medical indications for work therapy. In others there is a great deal of waste because of poor management or because of inattention to the culinary arts. In the newer hospitals the construction is of fireproof or semi-fireproof material, and provision is made for infirmary accommodations for at least 50 per cent of the patients. Formerly 25 per cent of infirmary beds was considered quite sufficient.

Hospitals for the Mentally Ill

There is no standard for determining the number of beds needed for the several types of mental diseases in a given state or local community. The demand for hospitalization for mental cases has been acute and it has evidently not been satis-

*"The Specialist: What Shall We Do with Him?" S. S. Goldwater, M. D., Jour. Am. Med. Asso., May 28, 1927.

factorily met in any of the states. All the hospitals for the insane are overcrowded and in many instances patients are discharged on parole too early for the benefit of the patient or the best interests of the community.

Many of the municipal and county hospitals have psychopathic wards for the temporary detention and study of the mentally deranged. Even within the short period allowed by the laws for holding patients of this type before committing them to state institutions, a great deal may be done in many instances to obviate the need of transferring them to a state institution. There are numerous instances of patients who are brought to the psychopathic division of a hospital, who seem to be in mild confusional states and who suffer from conditions bordering on insanity, but who under proper treatment could be sent back to their families within a relatively short period. This emphasizes the need for well staffed and competently directed departments of psychiatry in the large municipal and county hospitals.

Judge by Results

The efficacy of the work of the state hospitals for mental diseases is best measured by the results obtained. On the basis of the data secured by the Federal Census Bureau, January, 1923, a valuable study was prepared by Dr. Horatio M. Pollock, New York State Hospital Commission, Albany, N. Y. This was published by the National Committee for Mental Hygiene. This study affords a guide for individual institutions. According to the census tabulation, the number of resident patients in state hospitals for the insane on January 1, 1923, was 267,617, an increase of over 9,000 patients over the census of the same day a year earlier. For each 1000 patients residing at the hospital at the beginning of the year, there were 283 first admissions, 63 readmissions, 204 discharges, 99 deaths. There is a relatively higher ratio of first admissions of resident patients in cases of cerebral arteriosclerosis, general paralysis, drug and other toxic psychoses, and psychoneuroses and neuroses. Readmissions are most frequent in the alcoholic, manic depressive and dementia praecox types.

With reference to costs of maintenance of patients in the state hospitals, the data of New York hospitals may be of some interest. According to the last report of the New York state hospitals for the fiscal year ending June 20, 1926, the average cost per patient per year was \$396.79. This was an average for sixteen hospitals. The variations in cost from hospital to hospital are con-

siderable as will be seen from the accompanying table. The smaller the hospital, the higher its per capita, although often other elements are involved.

Comparative Statement of Per Capita Cost of Patients in New York State Hospitals for the Year Ended June 30, 1926*

Name of Hospital	Number of Patients	Cost per capita per annum
Binghamton	2,725	\$ 389.56
Brooklyn	1,589	485.56
Buffalo	2,211	414.15
Central Islip	5,742	361.14
Creedmoor	173	1,282.96
Gowanda	1,266	418.39
Harlem Valley	278	651.50
Hudson River	3,860	402.00
Kings Park	4,989	364.26
Manhattan	6,516	379.79
Marcy	865	460.31
Middletown	2,469	368.33
Rochester	1,741	417.87
St. Lawrence	2,286	372.36
Utica	1,654	436.71
Willard	2,502	402.74

Most of the infectious diseases are excluded from treatment in hospitals not devoted entirely to that type of service. Some hospitals have special accommodations for certain types of communicable disease. Most of the sanitary codes contain regulations that call for certain isolation facilities in every hospital. This is particularly true of hospitals for children.

Contagious Disease Hospitals

The problems underlying the organization and policies of infectious disease hospitals are naturally quite different from those of other types of hospitals. In American communities the majority of cases are sent in by the agents of the health department either because of lack of adequate facilities in the home of the patient or because of economic inability to provide adequate care. During recent years the former rather unenviable reputation of infectious disease hospitals has changed, as modern, aseptic methods and better nursing technique have been introduced, and the mortality has become lower in comparison with former years. Mortality is always higher in the hospitals than in the community at large because many cases are sent in too late for rational therapy, or suffer from various complications acquired prior to the removal to the hospital.

In some instances secondary infections develop within the hospital because of failure on the part of the personnel to observe the rules of strict

*"Tuberculosis Hospitalization," G. J. Drolet, Am. Rev. of Tuber., December, 1926.

*Thirty-Eighth Annual Report of the State Hospital Commission.

asepsis. The infectious disease hospitals have suffered from a lack of well trained personnel and an insufficiency of both physicians and surgeons. It has been shown that the mortality in a contagious disease hospital is in direct ratio to the amount of nursing care available per patient per diem. The experience of the Willard Parker Hospital, New York, is a striking example of the improvements that can be made without much additional expense, provided there be competent administration and conscientious medical direction.

Orthopedic Hospitals

Contrary to usual conception, the average stay of an orthopedic case need not exceed the average stay of any other surgical case. This was brought out strikingly in a report made by a special committee of the New York Committee on After Care of Infantile Paralysis Cases, in 1920. In one of the hospitals where the cases were studied seventy-seven cases were operated upon and discharged to their homes after an average stay of less than two weeks. The group comprised a variety of conditions and there were twelve types of operations performed. Another group of similar patients with nine types of operations had an average stay of fifty-two days. All the cases in the two hospitals returned at stated intervals for checking-up examinations. The results in the two groups compared favorably:

"The conclusion might be drawn that it would be feasible to discharge orthopedic cases operated upon within a period of two weeks, and that as good end results would be obtained as though they were kept in the hospital for a period of at least seven weeks. This is probably a fair conclusion as applied to the majority of cases, but there are other factors to take into consideration in addition to the end results."

Patient's Home Condition a Factor

One factor is the home condition of the patient and another is adequacy of provision for convalescent care in special institutions. In the same survey it was ascertained that the average period of convalescence in the orthopedic cases is at least ten weeks. Should a community have a sufficient number of convalescent homes for the care of orthopedic cases, it would greatly diminish the need of special hospitals where the cost of maintaining the patient is considerably higher than it is in a convalescent home. Before a community determines the need of hospital facilities for orthopedic conditions it would seem highly important to consider the available or projected facilities for the care of convalescents.

Maternity Hospitals

In the wake of the education that has been carried on by the health authorities has come a demand for larger hospital facilities for puerperal conditions. The midwife as a factor is gradually diminishing and the hospitals are resorted to by more and more women. There are some cities in which as high as 60 to 70 per cent of all deliveries take place in hospitals. Although it may not be true in any other city, the survey of hospitals in New York City, made several years ago by the public health relations committee of the New York Academy of Medicine, brought out the fact that the mortality of both mother and child is lower in the hospitals devoted exclusively to obstetrics than in the general hospitals having maternity services. Incidentally it would be a profitable thing to make similar comparisons in other communities to find out if the same situation prevails and, if so, the reasons for it.

Cancer Hospitals

The tragic and baffling nature of cancer is important not only from the medical but also from the sociological point of view. The large increase in the certified mortality from cancer has drawn public attention to it and the educational work that is carried on is bringing larger numbers of people to the physicians and hospitals. In spite of the progress that is being made in radiation and other forms of cancer treatment, surgery remains the most important factor. It is, therefore, of great importance that cancer surgery should be of a high level. Every hospital has cancer patients and everywhere cancer surgery is being done. Cancer specialists maintain that cancer surgery should be attempted only by people who have had special training, and they have emphasized the need of special hospitals set aside for the development of cancer research and technique. They point out the successful experience of the French cancer institutes, and at the recent international conference at Lake Mohonk the belief was expressed that special cancer institutes would be of great benefit and should be developed in this country.

The Care of Chronics

The chronic patient has been characterized as a challenge to the medical profession. The great majority of those afflicted with chronic ailments do not receive the study and therapeutic attention which their condition calls for both from a medical and economic point of view. It has been estimated that 50 per cent of all deaths are due to chronic diseases. There are few communities in

which the situation has been met in a satisfactory way. There is nowhere a clear differentiation between patients requiring merely custodial care and those who would be benefited by specialized nursing and medical attention. According to the Cleveland Hospital Survey, 42.7 per cent of the cases treated in their homes by the Visiting Nurses' Association suffered from chronic diseases in need of institutional care. If tuberculosis cases be excluded, the percentage of chronically afflicted would be still higher.

Among the patients in the out-patient departments of hospitals there are many who require more care and attention than may be furnished to ambulatory patients. I refer particularly to those who suffer from the various rheumatic diseases, and from cardiac and vascular troubles of various kinds and degrees; those with gastroenteric diseases who cannot carry out the required mode of life in their homes; those with affections of the neuromuscular system, with leg ulcers or renal affections.

Neither philanthropic munificence nor the city exchequers have been prone to provide adequate funds for the sorely needed facilities for the chronic patient. It remains one of the outstanding needs in a program of adequate hospitalization.

TO WHOM DO ROENTGENOGRAMS BELONG?

Careful search has failed to reveal any case in which a court has decided whether a person who is roentgenographed is, in the absence of an express agreement, entitled to the resulting roentgenogram. A somewhat similar question has been decided, however, with respect to the right of a person photographed to the photographic negatives incident to the process. Courts have held that the negative is the property of the photographer, subject to certain restrictions on its use.¹

But the parallel is not perfect; every one knows that a person who presents himself to a photographer to be photographed expects to receive a photograph and does not expect to receive any intermediate product of the process of manufacture. It is not clear, however, whether a person who presents himself to be roentgenographed expects to receive, and the roentgenologist expects to give, an opinion and advice, or a roentgenogram, or both. In the absence of an express agreement, a court that is called on to determine the question will try to find out what was in the minds of the parties to the transaction at the time it occurred. To that end it must look for proof of a reasonably definite and generally recognized understanding among roentgenologists and their patrons.

Proof of any understanding whatever among the non-professional public would probably be difficult. Persons of this class are referred to roentgenologists, present themselves for examination, and await the reports of the results, which they receive through their physicians. They do not stop, before being roentgenographed, to ask

whether or not they are going to receive roentgenograms.

Among roentgenologists and physicians generally, however, a common understanding is more readily susceptible of proof. A formal statement of that understanding by a representative professional group is to be found in resolutions adopted in 1920 by the Radiological Society of North America. There it is expressed as the sense of the society that all roentgenograms, plates, films, negatives, photographs, tracings or other records of examination are the exclusive property of the roentgenologist who made them or of the laboratory where they were made. The roentgenologist is declared to be a professional man, whose opinion and advice are sought; he is not a mere technician, paid to make a certain kind of photograph called a roentgenogram. He is a consultant in all cases in which he is called on to examine patients; therefore he is not to make known to a patient or to a patient's relatives, friends or guardian any of his observations or conclusions. He is not to deliver to any of them any plate, negative, film or print unless requested so to do by the physician who referred the patient for examination.

There Is No Express Agreement

Evidence showing a general acceptance by the profession of the principles laid down in these resolutions will go a long way, in the absence of an express agreement, toward settling the question of the ownership of the roentgenogram, if and when that question comes before the courts.

The fact that a roentgenogram was made by a hospital, through its roentgenologist, and not by a roentgenologist acting for himself, does not alter the situation just stated, except that it makes a stronger case for the retention of the roentgenogram by the hospital.

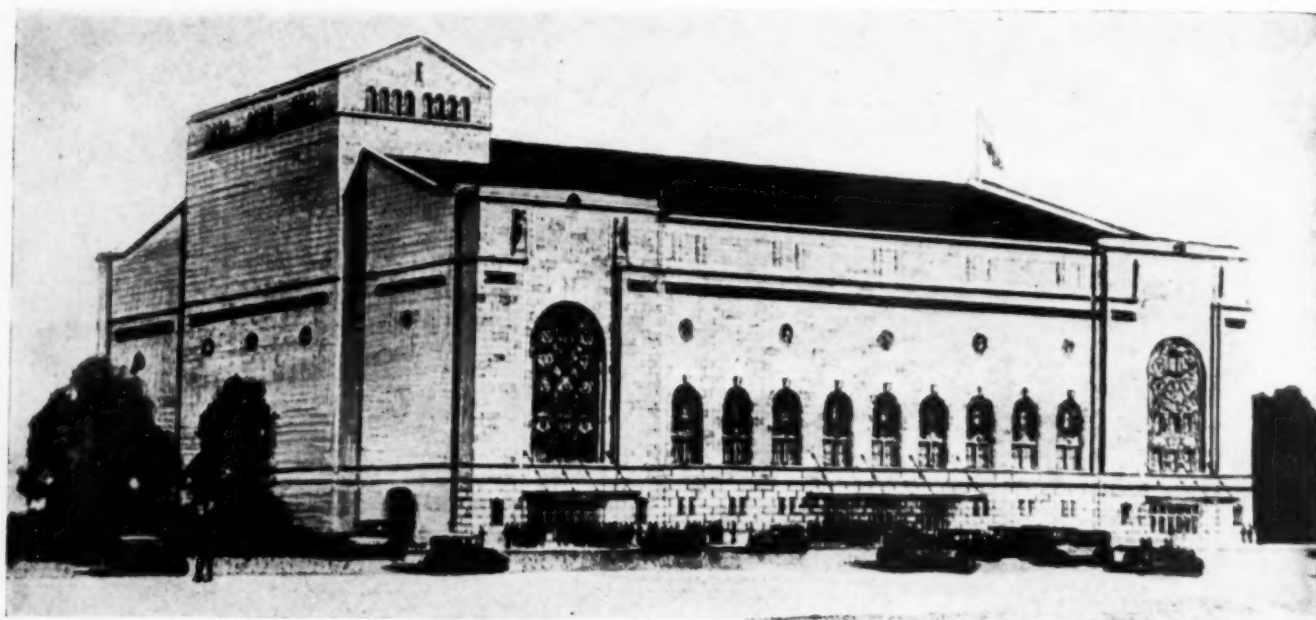
A hospital may make such reasonable regulations as are necessary for its efficient management. If any such regulation is in fact brought to the attention of a patient or a physician using the hospital, or if he has actual knowledge of that regulation, before he enters on such use, he is bound by it. The fact that the regulation is posted in and about the hospital or even that it has been customarily followed for a long time would tend to prove such knowledge on the part of a physician or a patient and to bind him accordingly. If any such regulation requires that the records, including roentgenograms, remain in the hospital, it would presumably be sufficient to compel a physician or a patient to leave his case records there.

Whether a patient may as a matter of right inspect his hospital records, including any roentgenogram that may form a part of it, or may have that record inspected on his behalf, or may make a copy of it or have a copy made, and whether he may require the hospital to provide him with a copy of the record on tendering the cost of making it, are questions that the courts have apparently not been called on to decide.

If such questions are fairly presented, a court may not unreasonably hold that a patient is entitled to make such an inspection or to have it made, under conditions that do not interfere with the orderly operation of the hospital. It seems not unlikely, too, that the court may hold that a patient is entitled to a copy of this hospital record so far as it is necessary to his welfare, at least on payment of the cost of preparing the copy.

The fact that these various questions have never been carried to the courts of last resort and possibly to no other courts suggests strongly that they are usually settled by the parties on the basis of equity and common sense—which, after all, is the best way to settle them.—*Journal of the American Medical Association.*

¹ Corliss et al. v. Walker Co. et al., 64 Fed. 280. Pollard v. Photographic Company, 49 Ch. Div. 345.



Minneapolis Municipal Auditorium—where we meet

ADMINISTRATIVE SECTION TO BE FEATURE OF A. H. A. MEETING

INTEREST in this year's program at the conference of the American Hospital Association centers around the administrative section. For several years past the meetings devoted to the everyday problems of the administrator have occasioned unusual interest, and without doubt these sessions have been more fully attended than any of the others.

At last year's meeting Frank E. Chapman, director, Mount Sinai Hospital, Cleveland, was appointed chairman of this section and from that time until the opening day of the convention he has been in constant correspondence with the hospitals of the United States and Canada, in an effort to ascertain with some degree of certainty just what questions should be presented and the importance of the presentation.

After preliminary letters were sent out and it was seen that there was a wide range of problems that should be discussed, it was decided that the most feasible manner in which to conduct the session was to eliminate prepared papers and speeches and reintroduce round table discussion. A few years ago Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago, introduced this feature, and its success at that time was unquestioned. Mr. Chapman reasoned that with Mr. Bacon's success as a precedent, it would be beneficial to introduce many questions and have them answered by the members themselves rather than by the reading of papers.

The questions that will be presented at the administration sections cover practically every phase of hospital administration and have been so arranged that those dependent upon each other or those related to each other will come together on the program as far as it is possible so to arrange them. Those who have had conspicuous success in solving certain problems will be present and will tell the "how" of the solution and all present will be urged not only to answer questions as they arise but also to present questions as they occur to them thus making the session of practical value.

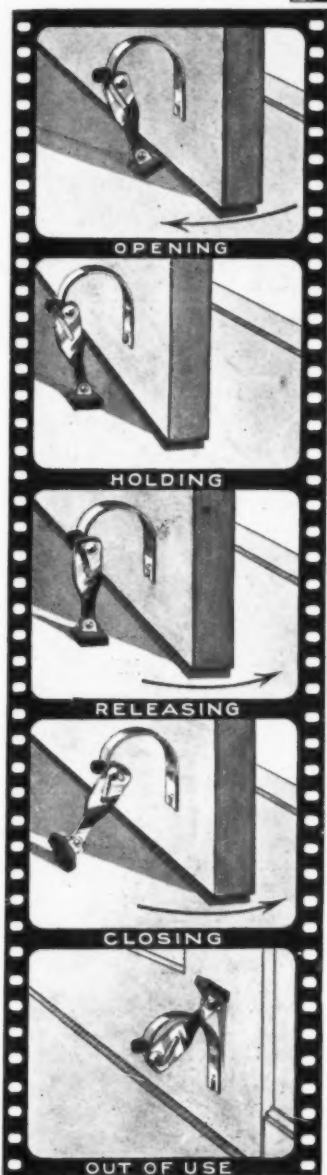
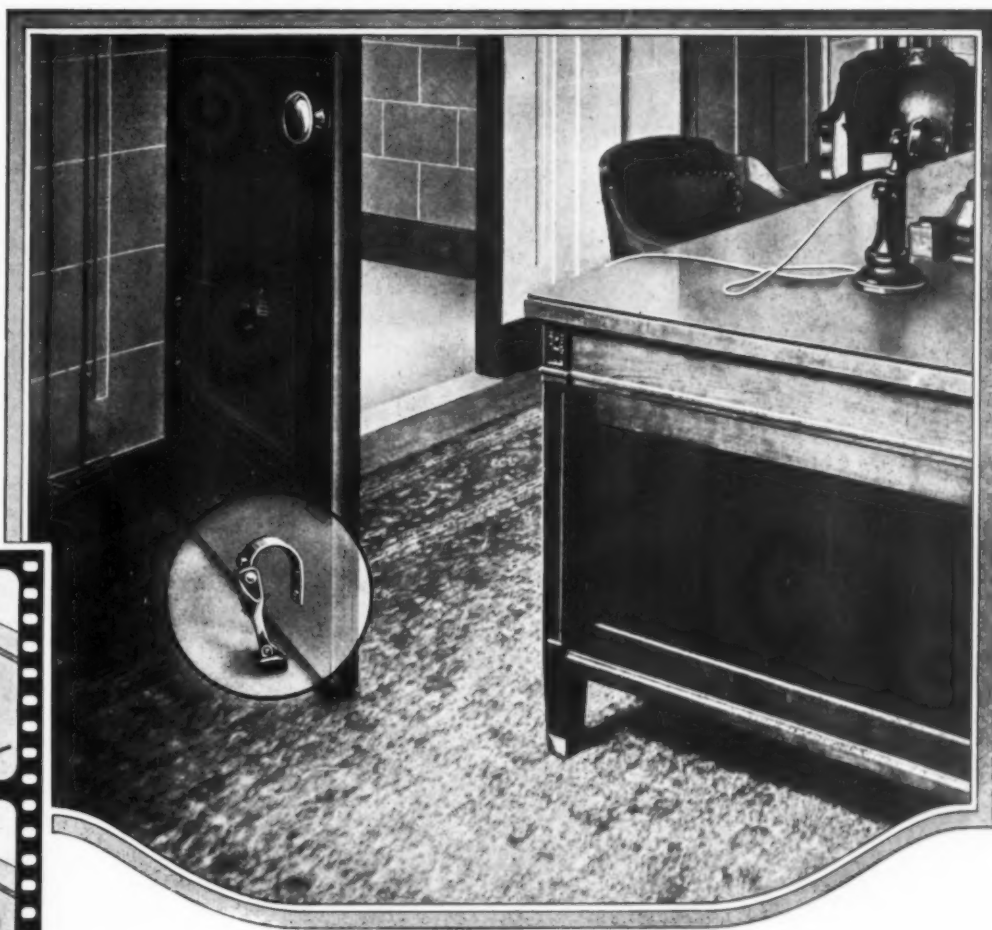
The first session to be held by the association will be called to order in the General Assembly Hall with Mr. Chapman presiding. Following the report of the intern advisory committee, which will be made by the chairman, Dr. Nathaniel W. Faxon, superintendent, Strong Memorial Hospital, Rochester, N. Y., will come discussions on the problems of the medical staff, the problems of general administration, the problems of the mechanical department and the problems of the laundry.

At the same time that the administration session is being held, the social service section will also get under way with Mary H. Combs, R. N., Brooklyn Hospital, Brooklyn, N. Y., presiding. At this section, which will assemble in Meeting Hall A, a symposium on the subject "Why the Small Hospital Needs a Social Service Department" will be discussed by the following: Dr. Nathaniel W. Faxon, Michael M. Davis, New York, and Ruth Emerson, director hospital social work, University of Chicago, Chicago. The discussion will be led by Dr. Hilding Bergland, professor of internal medicine, University of Minnesota, Minneapolis, and Joanna Colcord, general secretary, Family Welfare Society, Minneapolis.

On Monday evening in the General Assembly Hall with President Brodrick presiding, the opening general session will be held. Following the formal opening by President Brodrick invocation will be asked by Rabbi Albert G. Minda, Temple Israel, Minneapolis. The address of welcome from the state will be given by Hon. Theodore Christianson, governor of Minnesota, and this will be followed by an address of welcome from the city by Hon. George E. Leach, mayor of Minneapolis. William F. Kunze, chairman, Minneapolis Board of Public Welfare, Minneapolis, will also welcome the hospital executives, and on behalf of the American Hospital Association, Richard P. Borden, senior trustee of the association, will respond. Mr. Borden will then present the report of the board of trustees of the American Hospital Association.

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The address of the president, delivered by Dr. R. G. Brodrick, will be the main feature of the program and this will be followed by the reports of the treasurer and the secretary, concluding the meeting.

Dr. John D. Spelman, third vice-president of the association, will preside at the general session to be held in the General Assembly Hall on Tuesday morning at nine o'clock. At this time the report of the committee on accounting and records will be presented and Dr. A. C. Bachmeyer, director, Cincinnati General Hospital, Cincinnati, will also speak on the "Nomenclature of Diseases and Operations." This will be discussed by Dr. T. R. Ponton, superintendent, Hollywood Hospital, Hollywood, Calif., who has recently published a book on this subject. There will be a report of the membership committee given by Dr. Louis H. Burlingham, Barnes Hospital, St. Louis, and then will come the final report of this session, the report of the nominating committee, given by Dr. John M. Peters, superintendent, Rhode Island Hospital, Providence, R. I.

Tuesday afternoon's session will be presided over by Dr. Louis H. Burlingham, first vice-president of the association. One of the features of the program will be the report of the committee on simplification and standardization of furnishings, supplies and equipment, read by Margaret Rogers, superintendent, St. Luke's Hospital, St. Paul, Minn. Miss Rogers has given much time and thought to the report and it is expected that the work of this committee will make a deep impression on those present. Dr. R. O. Beard, professor emeritus, college of medicine, University of Minnesota, Minneapolis, will then present a paper given under the auspices of the American Library Association, entitled "The Library in the Hospital."

Mr. Borden will read the report of the committee on

workmen's compensation and the discussion on this report will be opened by R. V. Mothersill, secretary, Anchor Casualty Company, St. Paul, Minn. The session will close with the presentation of the "Certificates of Award" for National Hospital Day.

The association will return to the usual custom of a banquet on Tuesday evening, which will be held at the Hotel Radisson. The banquet will be under the auspices of the local committee on arrangements, of which Mr. Kunze is the chairman and Dr. Beard is the secretary. With Dr. Brodrick presiding the meeting will be opened with the presentation of past presidents and distinguished guests. The speaker of the evening will be Dr. Morris Fishbein, editor, *Journal of the American Medical Association*, Chicago, whose subject will be "The Hospital and the Community." Dr. Fishbein is well known as a speaker of force, and usually his speeches are liberally punctuated with excellent humor.

President Brodrick will preside at the general session which will be held in the General Assembly Hall on Wednesday morning. The meeting will be called to order at nine o'clock, and the first order of business will be the reading of the report of the committee on public health relations by Dr. D. L. Richardson, superintendent, Providence City Hospital, Providence, R. I. Dr. W. S. Rankin, director, the Duke Endowment, Charlotte, N. C., will open the discussion.

Dr. Ernst P. Boas, superintendent, Montiflore Hospital for Chronic Diseases, New York, will then present his paper, "Convalescent and Chronic Hospitals." This will be followed by a paper entitled "Study of Quantity and Unit Cost of Social Work."

The report of the committee on county hospitals will be given by the chairman of the committee, Dr. C. W. Munger, director, Grasslands Hospital, Valhalla, N. Y.



Dr. R. G. Brodrick, president



Dr. J. C. Doane, president-elect

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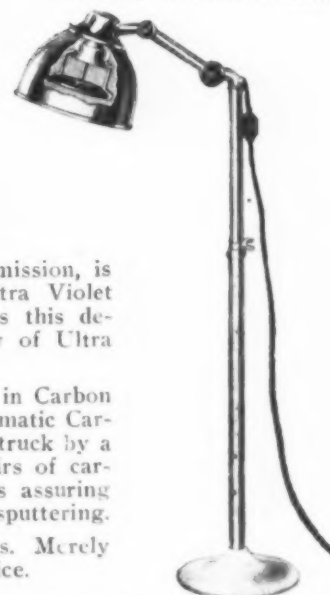
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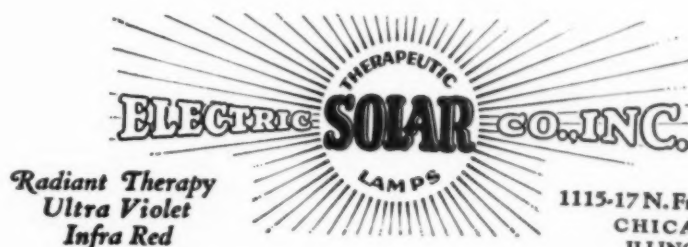
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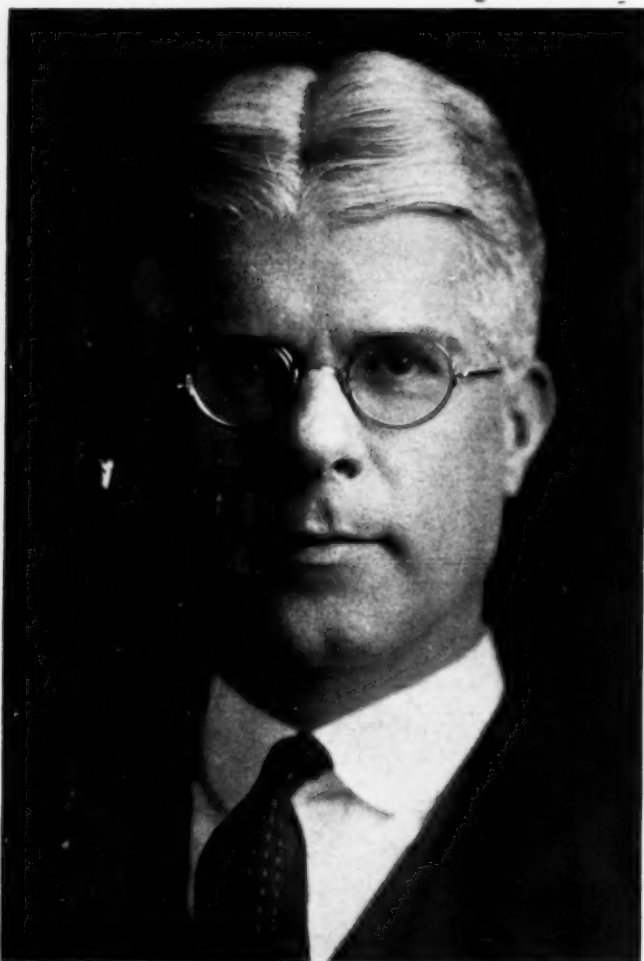


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Dr. Bachmeyer will open the discussion on the report. The report of the special committee on insignia will be given by the chairman, Dr. John F. Bresnahan, superintendent, St. Mark's Hospital, New York, and Mr. Borden will give the report on constitution and rules.

The second session of the administration section will be held on Wednesday afternoon in the General Assembly Hall with Mr. Chapman presiding. Hospital income and hospital expense will be the two major topics dealt with at this session and there will be a discussion by E. H. Lewinski-Corwin, New York Academy of Medicine, New York, on "Can Hospital Productivity be Measured?"

Also on Wednesday afternoon the first session of the dietetic section will be held with Mary A. Foley, Kahler



Dr. L. H. Burlingham, chairman of membership committee

Corporation, Rochester, Minn., presiding. Rena S. Eckman, dietitian, Montefiore Hospital, Pittsburgh, Pa., will give the report of the committee on dietary service and equipment and this will be discussed by Dr. Malcolm T. MacEachern associate director, American College of Surgeons, Chicago. There will also be a report on the training of student dietitians and this will be followed by a paper by S. Margaret Gillam, director, department of dietetics, University of Michigan Hospital, Ann Arbor, Mich. Miss Gillam has taken for her subject "Hospital Cafeterias." Dr. Louis B. Wilson, Mayo Foundation, Rochester, Minn., will be the next speaker with the subject "Education and Recreation." The last paper of this session will be "Irradiated Foods and the Effect of Sunlight on Food," by Charles Sheard, physicist, Mayo Clinic, Rochester, Minn.

*Frank E. Chapman,
chairman
of administration
section*



On Wednesday evening two sessions will be held simultaneously. The out-patient section, with Frank E. Wing, Boston, presiding, will be held in the General Assembly Hall and the small hospital section will be held in Meeting Hall A. Mary Yager will preside at this meeting.

Many subjects of interest to the administrators of tuberculosis hospitals will be presented at the general session to be held in the General Assembly Hall on Thursday morning. Dr. Glen L. Bellis, Wauwatosa, Wis., will act as chairman and there will be a symposium entitled "Tuberculosis Sanatoria." The program follows: "Need and Value of Modern Buildings and Equipment for Institutional Treatment of Tuberculosis," Dr. Ernest S. Ma-



*John D. Spelman,
third
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riette, Glen Lake Sanatorium, Oak Terrace, Minn.; "General Principles of Planning and the Classifications of Accommodations of the Modern Tuberculosis Sanatorium," T. B. Kidner, consultant on sanatorium planning, New York; discussion by Dr. Joseph R. Morrow, Bergen County Hospital, Ridgewood, N. J.; "Porches and Other Facilities for Open Air Treatment," Dr. A. J. Davis, Nassau County Sanatorium, Farmingdale, N. Y.; discussion, I. Rosenfield, architect, New York; "Planning Auxiliary and Service Rooms," speaker to be assigned; discussion, Dr. Ernst P. Boas, director Montiflore Hospital for Chronic Diseases, New York; "Planning for Food Service," Charlotte Jane Garrison, R. N.; discussion, Dr. Harry John Corper, National Jewish Hospital, Denver, Colo.; "The General Hospital and Tuberculosis," Dr. J. A. Myers, associate professor preventive medicine and public health, University of Minnesota, Minneapolis; discussion, Dr. B. S. Pollak, Hudson County Sanatorium, Secaucus, N. J.

The construction section with Dr. George D. O'Hanlon, superintendent, Jersey City Hospital, Jersey City, N. J., presiding, will be held in the General Assembly Hall on Thursday afternoon. A round table will be held this year and there will be the report of the committee on buildings—construction, equipment and maintenance. Dr. S. S. Goldwater, Mount Sinai Hospital, New York, chairman of the committee will not be present at the meeting of the association this year. The following subjects are listed for round table discussion:

Should the Nurses' Home Conform to the Private Home Standard Rather than to the Institutional Standard?"

What Consumption of Electricity Warrants a Hospital Installing Its Own Independent Plant?

What Provisions, If Any, Are Desirable for an Emergency Lighting System?

Experience of Different Institutions with Various Kinds of Elevators.

Concealed versus Unconcealed Piping.

A round table will also be held by the out-patient sec-



Ada Belle McCleery, chairman of nursing section

tion on Thursday afternoon at 2 p.m. in Meeting Hall A.

On Thursday evening in the General Assembly Hall, the nursing section will be held with Ada Belle McCleery, superintendent, Evanston Hospital, Evanston, Ill., presiding. Among the many subjects that will be presented will be the question of the grading of nursing schools, by Dr. May Ayres Burgess, New York.

At the same time the trustees section will be held with David C. Shepard, president, St. Luke's Hospital, St. Paul, Minn., presiding. At this time the report of the committee on fire insurance will be given by Dr. Joseph C. Doane, director, Philadelphia General Hospital, Philadelphia, and the opening discussion will be given by L. D. Wood, General Fire Insurance Company, Philadelphia, followed by a discussion led by J. B. Levinson, president, Mount Zion Hospital, San Francisco, Calif.

After the insurance question has been discussed Dr. John A. Lapp, National Catholic Welfare Conference, Chicago, will read a paper on "Legal Responsibilities of Hospital Trustees."

Dr. Burlingham will preside at the Friday morning session in the General Assembly Hall, when Dr. Lewis A. Sexton, superintendent, Hartford Hospital, Hartford, Conn., will present the report of the committee on clinical and scientific equipment and work. This will be followed by a report from Edward A. Fitzpatrick, Graduate School, Marquette University, Milwaukee, Wis., for the committee on training of hospital executives. The report of the legislative committee by Dr. E. T. Olsen, superintendent, Englewood Hospital, Chicago, will close the meeting.

On Friday afternoon President Brodrick will preside and Mr. Borden will present the report of the committee on constitution and rules; Dr. Winford H. Smith, director, Johns Hopkins Hospital, Baltimore, Md., will present the report of the committee on Smithsonian Institute Exhibit, and Dr. B. W. Caldwell, superintendent, Gordon Keller Memorial Hospital, Tampa, Fla., will give the report of the resolutions committee. The report of the election returns will be read and the new president will take the chair.



Asa S. Bacon, treasurer

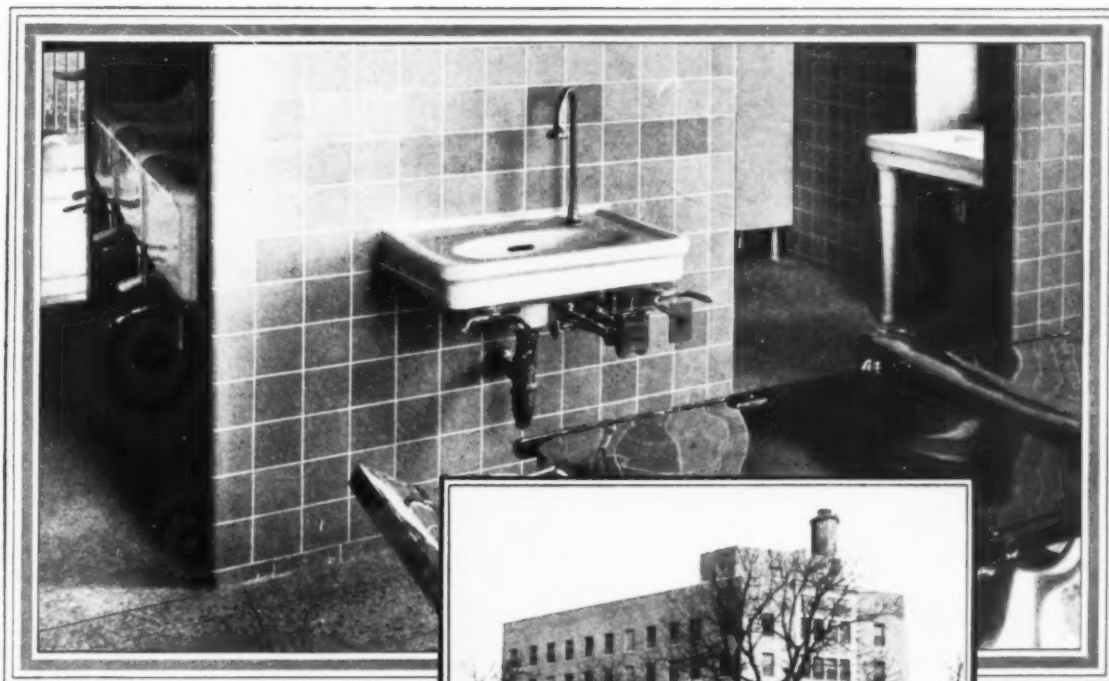
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WHERE TO GO AND WHAT TO SEE IN TWIN CITIES' HOSPITALS

MANY of the people attending the meetings in Minneapolis will undoubtedly be interested in visiting some of the many excellent institutions that are to be found in the Twin Cities. In order to facilitate these visits herewith are published the hospitals' locations, how to reach them from the auditorium, what to see at each of them and the best hours for visiting:

Abbott Hospital, First Avenue South between Seventeenth and Eighteenth Streets, Minneapolis. Walk one block west to First Avenue, then south to Seventeenth Street (only five blocks) or walk west to south-bound Nicollet Avenue car, get off at Seventeenth Street and walk one block east. The pediatric department is this hospital's feature and may best be seen between two and five o'clock in the afternoon. There will be a guide for visitors.

The Amherst H. Wilder Dispensary, Rice and Summit Avenue, St. Paul. Take Selby-Lake bus in front of Curtis Hotel. Get off at corner of Ninth Street and Summit Avenue and walk one block east and one block south on private driveway to Miller Hospital, and then one block east to Rice Street entrance of dispensary. Persons visiting the Miller Hospital may also visit this dispensary which is connected by tunnel. Esther Anderson will be on duty to show visitors through.

Ancker Hospital, Jefferson and Colborne Streets, St. Paul. Take St. Paul bus at Curtis Hotel to Union Bus Depot, St. Paul. Walk one block north to Seventh Street and take any street car going west on Seventh Street except Rondo-Maria or Dale-Phalen. Get off at Jefferson Street and walk two blocks east. This hospital has a new contagious unit which can be seen any afternoon from one to five o'clock if visitors will apply at the office of the superintendent of nurses.

New Asbury Hospital, 916 East Fifteenth Street, Minneapolis. Walk south to Fifteenth Street, then east to Elliot Avenue (about nine blocks) or walk west to north-bound Nicollet Avenue car and transfer at Eighth Street to south-bound Chicago Avenue car. Get off at Fifteenth Street and walk one block east. There will be a guide to show visitors through this new hospital.

Bethesda Hospital, Ninth and Wacouta Streets, St. Paul. Walk west to north-bound Nicollet Avenue car and transfer at Fifth Street to the St. Paul car. Transfer at Wabasha and Seventh Street, St. Paul, to any car going east on Seventh Street. Get off at Wacouta Street and walk two blocks north. Or take the St. Paul bus at the Curtis Hotel to Eighth and Robert Streets and walk three blocks east and one block north. Olga Hagman, R.N., will guide visitors through the institution. Visitors are welcome at any time.

Eitel Hospital, corner West Fourteenth and Willow Streets, Minneapolis. Walk west five blocks to Loring Park and one block south. Films, x-ray readings and general surgery can best be seen in the morning; eye, ear, nose and throat work in the afternoon. Mrs. Hummel, R. N., will conduct visitors through the institution.

Fairview Hospital, 2316 Sixth Street South, Minneapolis. Walk west to north-bound Nicollet Avenue car and transfer at Washington Avenue to any south-bound Minnehaha or Riverside car. Get off at Twenty-third Avenue and walk one block north. Surgery can best be observed between eight and ten o'clock in the morning.

Gillette State Hospital for Crippled Children, 1003 Ivy Street, St. Paul. Walk west to north-bound Nicollet Avenue car and transfer at Fifth Street to St. Paul car. Transfer at Seventh and Wabasha Streets, St. Paul, to the east-bound Dale-Phalen car. Get off at Ivy Street and walk one block east. Orthopedic operations are performed Tuesday, Wednesday and Saturday morning at eight-thirty, orthopedic clinics Friday morning at nine. Work in the physiotherapy department may be seen to best advantage between nine and eleven o'clock every morning except Thursday.

Glen Lake Sanatorium, Oak Terrace. Walk east to north-bound Fourth Avenue and Western car. Get off at Seventh Street and First Avenue North at the Union Bus Depot. Take Glen Lake bus, running every half hour, to the sanatorium. There will be open house every morning from nine to twelve and every afternoon from three to five. A diagnostic clinic will be held from one-thirty to three Monday afternoon.

Lutheran Deaconess Hospital, 1412 East Twenty-Fourth Street, Minneapolis. Walk north to Eleventh Street and take east-bound Franklin and Eleventh Street car. Get off at Fifteenth Avenue and walk three blocks south.

Midway Hospital, University Avenue and Aldine Street, St. Paul. Walk west to north-bound Nicollet Avenue car and transfer at Fifth Street to the St. Paul car. Get off at Snelling Avenue and walk two blocks west and one block south. Emergency work can best be seen between eight and ten o'clock in the morning. Ruth Nelson, R. N., will show visitors through this department.

Charles T. Miller Hospital, 125 West College Avenue, just west of Rice Street, St. Paul. Take Selby-Lake bus in front of Curtis Hotel and get off at the corner of Ninth Street and Summit Avenue. Walk one block east and one block south on private driveway, or get off at College Avenue. The majority of departments will best be seen in the forenoon.

Minneapolis General Hospital, Fifth Street and Sixth Avenue South, Minneapolis. Walk east to Sixth Avenue, then north to Fifth Street (about ten blocks) or walk east to north-bound Fourth Avenue car, get off at Fifth Street and walk two blocks east. The general hospital can best be seen between ten and twelve o'clock in the morning and from one to five in the afternoon. There will be a guide to show visitors through.

Mounds Park Sanitarium, Earl Street and Indian Mounds, St. Paul (general hospital with special psychiatric department). Walk west to north-bound Nicollet Avenue car and transfer at Fifth Street to St. Paul car. Transfer at Seventh Street, St. Paul, to the east bound Rondo-Maria car, get off at the end of the line and walk one block.

Northern Pacific Beneficial Association Hospital, 1515 Charles Street, St. Paul. Walk west to north-bound Nicollet Avenue car and transfer at Fifth Street to St. Paul car. Get off at Simpson Street and walk two blocks north. A guide to show visitors through the hospital may be secured at the registration desk. Operating rooms are usually in use from eight-thirty to twelve o'clock daily, and on Wednesdays from one to three o'clock a skin clinic is conducted.

Northwestern Hospital, Twenty-seventh Street and Chicago Avenue, Minneapolis. Walk west to north-bound

This advertisement, one of a series now appearing in *World's Work*, broadcasts the message that fire can often be stopped at its source—at the doorways, "where fire first breaks through."



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FIRE enters at doorways. How important then, particularly in hospitals, to fireproof this critical point. With Pyrono Fireproof Doors it can be done not only at a cost surprisingly low, but with the effect of giving the hospital the homelike beauty of real wood veneer work. Pyrono, in actual test, has withstood the intense heat of a blowtorch for an hour and over without showing any ill effects on its reverse side. Learn how these wood doors are fireproofed, not by "treating" the wood, but by actually bonding asbestos sheathing between veneer and core. Write The Compound & Pyrono Door Company, St. Joseph, Michigan.

Nicollet Avenue car and transfer at Eighth Street to south-bound Chicago Avenue car. Get off at Twenty-seventh Street in front of the hospital. Visitors are welcome at any time to the obstetrical and surgical departments.

St. Barnabas Hospital, 901 South Sixth Street, Minneapolis. Walk west to north-bound Nicollet Avenue car and transfer at Eighth Street to south-bound Chicago Avenue car. Get off on Eighth Avenue and Sixth Street and walk one block east.

St. John's Hospital, corner Sixth Street and Mounds Boulevard, St. Paul. Walk west to north-bound Nicollet Avenue car and transfer at Fifth Street to St. Paul car. Transfer at Seventh Street, St. Paul, to Rondo-Maria, Dale-Phalen or Snelling-Minnehaha car going east on Seventh Street and get off at Maria Avenue.

St. Joseph's Hospital, Ninth and Exchange Streets, St. Paul. Walk west to north-bound Nicollet Avenue car and transfer at Fifth Street to the St. Paul car. Get off at Wabasha and Exchange Streets and walk one and one half blocks south. Surgical work can best be seen between eight and eleven o'clock in the morning. Visitors will be conducted through the maternity department and the new nurses' home at any time.

St. Luke's Hospital, Smith Avenue and Sherman Street, St. Paul. Walk east to south-bound Fourth Avenue car and transfer at Lake Street to Selby-Lake car going east. Get off at Smith Avenue and walk two blocks south. The feature of this hospital is a newly organized diagnostic laboratory with a newly equipped clinical laboratory, x-ray and electrocardiographic departments. Blanche Pinkus will receive visitors.

St. Mary's Hospital, 2500 South Sixth Street, Minneapolis. Walk west to north-bound Nicollet Avenue car and transfer at Washington Avenue to any south-bound Minnehaha or Riverside car. Get off at Twenty-fifth Avenue and walk one block north.

St. Paul Hospital, Robert and University Avenues, St. Paul. Walk west to north-bound Nicollet Avenue car and transfer at Fifth Street to St. Paul car. Get off at State Capitol building, Central Avenue, and walk two blocks east.

Shriners' Hospital for Crippled Children, 2025 East River Road, Minneapolis. Walk north to Eleventh Street and take east bound Franklin Avenue car. Get off at the end of the Franklin Avenue bridge and walk eight blocks south to hospital.

Swedish Hospital, Tenth Avenue, between Seventh and Eighth Streets, Minneapolis. Walk north on Third Avenue to Seventh Street, then east to Tenth Avenue (about thirteen blocks) or walk west to north-bound Nicollet Avenue car and transfer at Eighth Street to south-bound Chicago Avenue car. Get off at Seventh Street and Chicago Avenue and walk two blocks east. The surgery and maternity departments are of special interest. There will be a guide to show visitors through.

Thomas Hospital, 2340 Sixth Street South, Minneapolis, for tuberculous patients only. Walk west to north-bound Nicollet Avenue car and transfer at Washington Avenue to any south-bound Minnehaha or Riverside car. Get off at Twenty-third Avenue and walk one block north. Visitors are received between ten and twelve o'clock in the morning and three and five o'clock in the afternoon.

U. S. Veterans' Hospital No. 68, 914 Elliott Avenue, Minneapolis. Walk two blocks south to Fourteenth Street, then east to Elliott Avenue (about eight blocks), or walk west to north-bound Nicollet Avenue car and transfer at

Eighth Street to south-bound Chicago Avenue car. Get off at Fourteenth Street and walk one block east.

U. S. Veterans' Hospital No. 106, Fort Snelling Reservation. Walk west to north-bound Nicollet Avenue car and transfer at Washington Avenue to south-bound Minnehaha-Plymouth car. Get off at hospital stop and walk west.

University of Minnesota Hospital, University of Minnesota campus, Minneapolis. Walk west to north-bound Nicollet Avenue car and transfer at Fifth Street to St. Paul car. Get off at Union Street and walk two blocks south. The x-ray therapy and radium plant, as well as the physical therapy laboratory are the features of this teaching hospital. There will be a guide for visitors every day during the conference.

STATE ASSOCIATIONS TO HOLD LUNCHEONS DURING CONVENTION WEEK

The usual custom of state organizations holding breakfasts and luncheons will be followed this year at the Minneapolis meeting. The tentative plans of some of the organizations are listed herewith:

The Pennsylvania Hospital Association will hold a luncheon at the Hotel Radisson, Wednesday noon.

The Wisconsin Hospital Association will hold a luncheon at the New Nicollet Hotel, Wednesday noon, October 12.

There will be a meeting of the Mid-West Hospital Association during the convention. Dr. B. A. Wilkes, superintendent, Missouri Baptist Sanitarium, St. Louis, who is president of the association, will make an announcement of the time and place after reaching Minneapolis.

The Indiana Hospital Association will hold a luncheon during the week, according to Missouria Martin, secretary of the association. A notice will be posted on the bulletin board at the Auditorium.

The Hospital Association of Illinois will hold a breakfast, Wednesday, October 12. Dr. Paul W. Wipperman states that he will announce the hotel at the opening day of the conference.

The South Dakota Hospital Association will hold a luncheon Tuesday noon, October 11, at the Andrews Hotel it has been announced by D. L. Brascamp, secretary of the association.

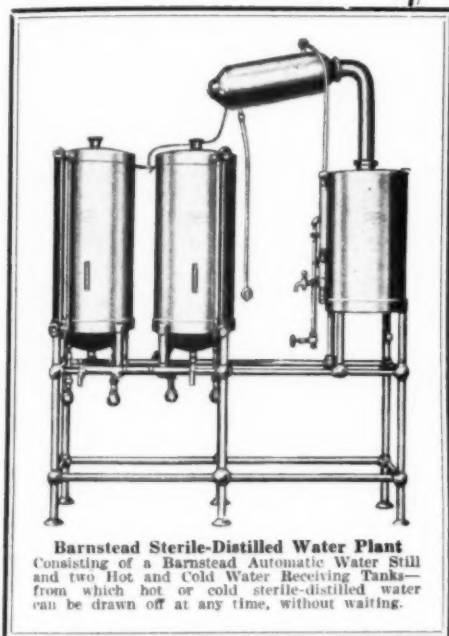
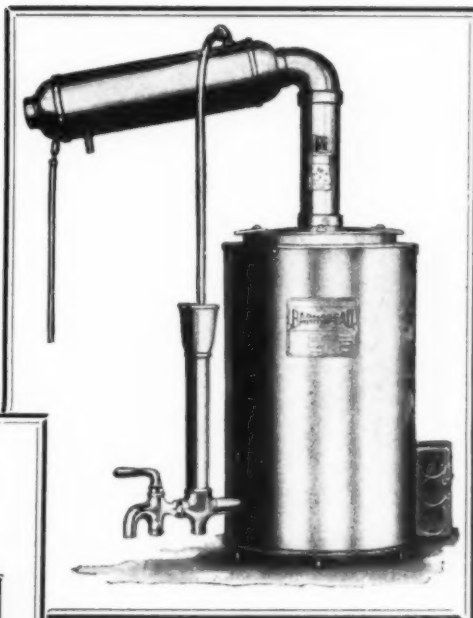
The Ohio Hospital Association will hold a luncheon at the Andrews Hotel, the time and date to be announced at the meeting.

The Colorado Hospital Association will probably hold a luncheon on Wednesday, October 12, at the New Nicollet Hotel. Ten delegates from this association have been selected to attend the meeting.

SHORT COURSES IN SOCIAL WORK TO BE GIVEN

In connection with the annual Illinois Conference on Public Welfare, to be held in Chicago, October 17 and 18, courses of study will be given for social workers and others concerned in social work. There will be five courses, each consisting of four sessions and costing \$3. Enrollment in each course will be limited and no one can take more than two courses. Dr. Herman M. Adler, director, Institute for Juvenile Research, Chicago, will be among the instructors and other instructors will be officers of various national organizations engaged in public welfare work. Inquiries should be addressed to the chairman, 848 North Dearborn street, Chicago.

A needed Safeguard



Barnstead Sterile-Distilled Water Plant
Consisting of a Barnstead Automatic Water Still and two Hot and Cold Water Receiving Tanks—
from which hot or cold sterile-distilled water
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hospitals are not extending the use of distilled water through their various departments merely as a fad.

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But it goes much farther than that. The fast-growing, more general use of distilled water clearly indicates a recognition of the fact that a hospital—of all places—should exercise **every** possible care to insure the safety and best welfare of its "guests" and those who minister to them. Sterile-distilled, chemically-pure water—germ free and mineral free—is the one, **absolutely safe water that can be used for all purposes.** No filtering or boiling or "treating" method can actually and thoroughly purify; nor has ordinary condensed "boiler-steam," sometimes called distilled water, any claim to purity. Sterile-distilled water also has a widely acknowledged therapeutic value. **To employ only sterile-distilled water for routine use in a hospital, is to play safe—and to advance the reputation of that hospital.** Read the Barnstead Distilled Water Handbook. Complimentary copy will be sent you at your request.

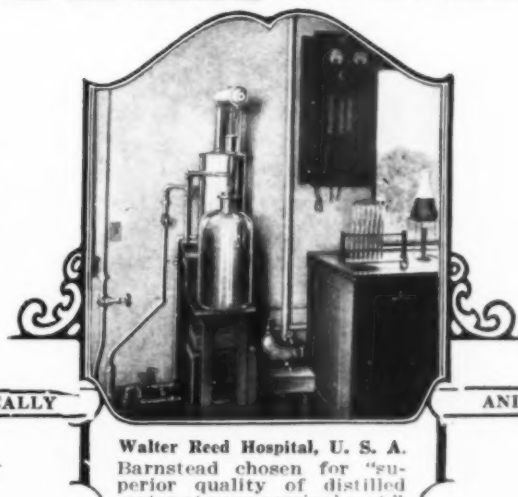
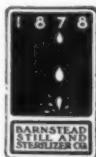
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Producing fresh sterile-distilled, chemically-pure (excelling U.S.P.) water for use in

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Nowhere, more than in the hospital, is accuracy in laboratory work demanded. And nothing contributes more to accuracy than laboratory equipment that is right in every respect:

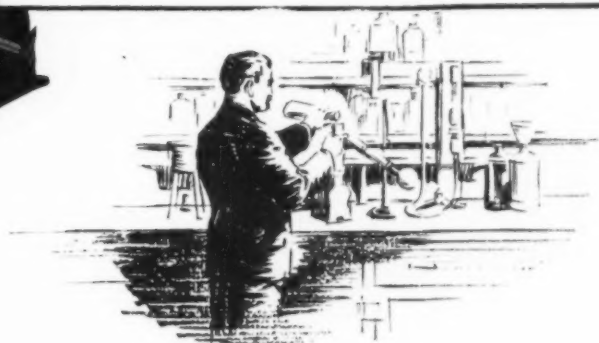
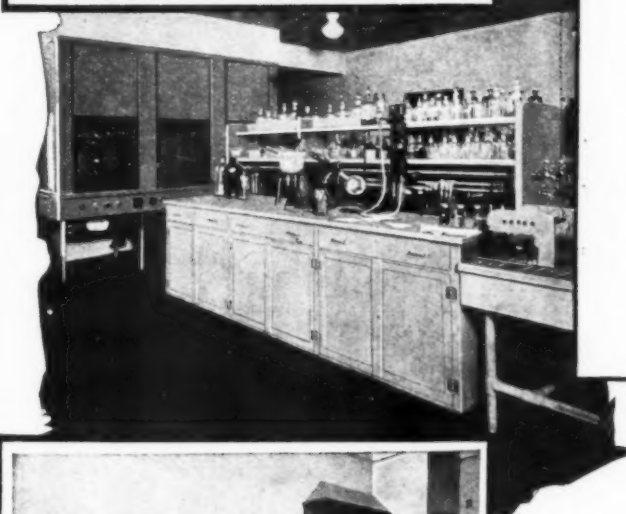
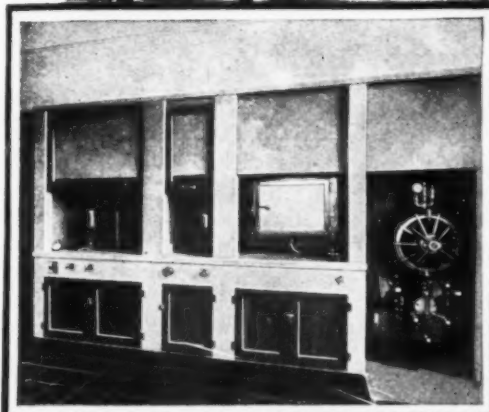
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And out of those 20 years of experience, Alberene engineers have acquired a fund of specialized experience in laboratory layout and design which is absolutely unequalled.

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Write for the Laboratory Bulletin



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PROTESTANT HOSPITAL ASSOCIATION PROGRAM

THE program for the meeting of the American Protestant Hospital Association to be held at the Curtis Hotel Auditorium, October 8, 9 and 10 is as follows:

Convention called to order, 9:45 a.m., followed by devotions conducted by Rev. Louis T. Talbot, D.D., pastor, Olivet Presbyterian Church, Minneapolis; "The Purpose of Our Convention," Dr. Frank C. English, executive secretary; annual address of the president, "Get Acquainted," Robert Jolly, president of the association and superintendent, Baptist Hospital, Houston, Texas; "The Church's Increasing Responsibility for Maintaining Hospitals," Dr. L. J. Bristow, secretary, Hospital Commission of Southern Baptist Convention, New Orleans, La.; "How Much Ought a Hospital to Do for Its Employees and Student Nurses?" Albert J. Hahn, business manager, Deaconess Hospital, Evansville, Ind.; "How to Develop a System to Finance Hospitals Doing a Large Amount of Free and Part Pay Work," R. S. Williams, financial secretary, Mounds Park Sanitarium, St. Paul, Minn.; The Saturday Round Table, "Hitting the Mark," conducted by Dr. C. S. Woods, superintendent, St. Luke's Hospital, Cleveland; adjournment for lunch.

The second session will open at 2 p.m., with the report of the standing committee. Symposium, general theme

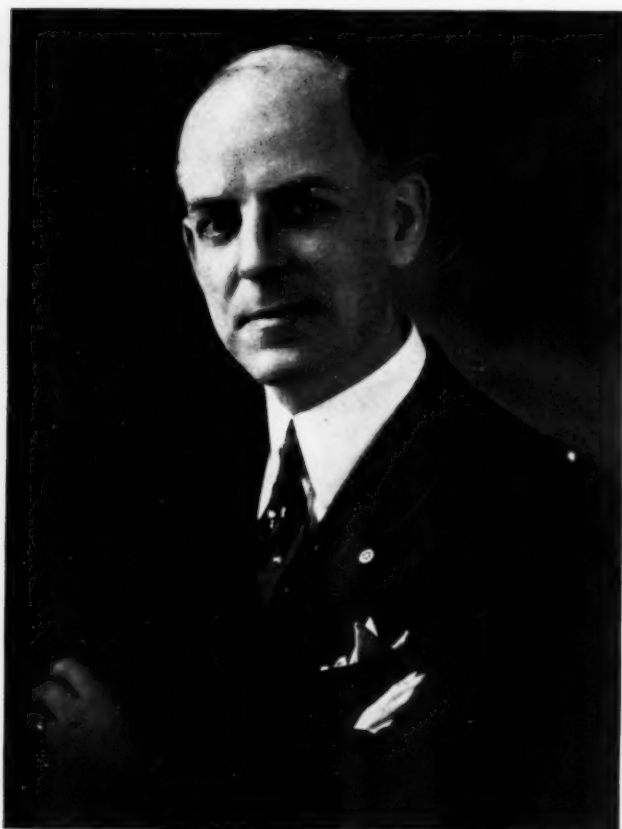
manager, Bethesda Hospital, Cincinnati; (d) What Does an Administrator Administrate? Luther G. Reynolds, superintendent, Methodist Hospital, Los Angeles, Calif. At 5:10 p.m. there will be a motion picture entitled "The Origin and Development of Biological Products."

The third session will be the annual banquet held at the Curtis Hotel, at 7 p.m. There will be two speakers for this occasion, Dr. Malcolm T. MacEachern, associate director, American College of Surgeons, Chicago, who will speak on "What Constitutes a Class A Hospital?" and Dr. Thomas A. Hyde, superintendent, Christ Hospital Jersey City, N. J., who will speak on "The History of the Rise and Development of the Episcopal Hospitals in America." Music will be supplied by the Nurses' Glee Club of Minneapolis.

The fourth session will be held on Sunday afternoon at 2:30 p.m., when there will be a mass meeting in the form of a song and devotional service. The general theme of this session will be "My Mental and Spiritual Philosophy of Life—Does It Hold?" The leader of this session will be President Jolly. At 3:40 p.m. there will be group meetings for denominational hospital representatives.

The fifth session will be held at Westminster Presbyterian Church, when there will be devotions by the pastor, music by the church choir, a motion picture and talk by Dr. W. C. Stoner, diagnostician, St. Luke's Hospital, Cleveland, on his recent trip through Europe, and an address by the Rt. Rev. James Wise, D.D., the Episcopal Bishop of the Kansas Diocese, Topeka, Kans.

The sixth and final session will be held Monday morning, opening with devotions conducted by the Rev. A. F. Almer, D.D., Bethesda Deaconess Hospital, St. Paul, Minn. Following this will be the election of officers. The following is the program of speakers: "What the Grading Committee Has Done," Dr. May Ayres Burgess, Committee on the Grading of Nursing Schools, New York; "School of Nursing Accounting," Dr. J. Stewart Hamilton, Harper Hospital, Detroit; the Monday Round Table, conducted by Paul Fesler, superintendent, University of Minnesota Hospital, Minneapolis.



Robert Jolly, president

"The Efficient and Economic Administration;" (a) The Culinary Department, Mrs. Margaret Marlowe, dietitian, Methodist Hospital, Indianapolis, Ind.; (b) Housekeeping and Upkeeping Departments, Carolyn E. Davis, superintendent, Minor Hospital, Seattle, Wash.; (c) How to Make Collections Just, Equitable but Certain to Produce the Necessary Income, Rev. F. O. Barz, D.D., business

CHICAGO COMMITTEE WILL AID DELEGATES TO PROTESTANT MEETING

A committee of welcome to Chicago has been named by Dr. Frank C. English, executive secretary, American Protestant Hospital Association, Cincinnati. This committee will meet delegates going to the Protestant meeting at Minneapolis, October 8, 9 and 10, and will endeavor to be of service to them while they are in Chicago.

It is requested that delegates get in touch with some member of the committee, notifying him if they want hotel reservations, if there is any particular hospital in Chicago that they wish to visit, any particular hospital service they wish to see, or if they need railroad reservations. The committee will be glad to do anything that will make the visit to Chicago more worth while and pleasant.

The committee appointed by Dr. English consists of John A. McNamara, executive editor, *THE MODERN HOSPITAL*, 660 Cass street; Asa S. Bacon, superintendent, Presbyterian Hospital; E. S. Gilmore, superintendent, Wesley Memorial Hospital, and Matthew O. Foley, managing editor, *Hospital Management*, 537 South Dearborn street.

Keeping Pace With Progress

Every other profession except that of raising money for hospitals has kept pace with the march of the times. In fund raising alone have the hands of the clock stood still during the past decade. It remained for the Kern organization to sound the new note in this field.

Any system, grown stale from over-use, must be discarded and new machinery and methods installed to meet changes in the modern social structure.

The old method of raising funds for hospitals based its chance for success on a purely philanthropic plea. When the intensive organization system was new this plan proved very successful but over-use has dulled its edge. It no longer brings 100 per cent of the results possible in a given field.

The new Kern Method retains all that is best in the old system but introduces a new type of service by the hospital to its public which assures every contributor of an actual dollars' and cents' value to himself for his support to the hospital.

The new plan for financing hospital progress is a business proposition from first to last. The hospital meets its public on a business basis. When you know more about the plan you will see that it must succeed.

Best of all, the long term pledge with its heavy shrinkage is discarded. The hospital is able to realize on the net results of the campaign without undue delay, and in addition a permanent annual income is assured. This income in its first year should more than meet total campaign expenses and still leave a healthy surplus.

We urge you for the good of your hospital to communicate with us and let us tell you more about this new business plan which will bring success to hundreds of hospitals in the immediate future.

(Even if yours is a privately owned institution, write or wire us and we can solve your problems.)



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Many Hospitals have grown through using our services.

HELPFUL PROGRAM AWAITS SOCIAL WORKERS AT MINNEAPOLIS

“WHY the Small Hospital Needs a Social Service Department” will be the subject discussed at the coming meeting of the American Association of Hospital Social Workers, to be held October 10 to 14, at Minneapolis, Minn., during the annual meeting of the American Hospital Association.

Hospital social workers will make their headquarters at the Sheridan Hotel where Mary Smith, University Hospital, Minneapolis, and chairman of the committee on local arrangements has secured suitable accommodations for members. Miss Smith and her committee have planned many attractive and interesting entertainment features for the delegates. Cooperating with the American Hospital Association, there will be a trip to Glen Lake Sanatorium, Oak Terrace, Minn. There will be a tea at Wilder Dispensary, St. Paul. Local hospital social service departments are planning small group dinners for the visiting delegates and there will be a dinner meeting with the Minneapolis Social Service Club.

Members of the executive committee will meet at the Sheridan Hotel on Monday morning, October 10, at 10:30 a. m., to transact the necessary business of the association. There will probably be an adjourned executive committee meeting immediately following the afternoon session at 4 p. m., also in the Sheridan Hotel. Executive committee members are asked to keep this time open.

Will Meet With A. H. A.

On Monday afternoon, October 10, at 2 p. m., there will be the social service section of the American Hospital Association. The speakers will present the reasons why a small hospital needs a social service department from several different points of view. Ruth Emerson, director of social work, Albert Merritt Billings Hospital, University of Chicago, Chicago, will speak from the point of view of the patient. Michael Davis, Committee on Dispensary Development, United Hospital Fund, New York, will speak from the point of view of the community. Mr. Davis needs no introduction to hospital audiences, and his opinions are based on his wide experience in the field of hospital and dispensary development. Dr. Nathaniel W. Faxon, director, Strong Memorial Hospital, Rochester, N. Y., will present the hospital administrator's point of view. Dr. Hilding Bergland, professor of internal medicine, University of Minnesota, will discuss the papers. It will be helpful to get the expression of an educator and physician. Joanna Colcord, general secretary, Minneapolis Family Welfare Association, Minneapolis, will also discuss the papers. Miss Colcord is an authority in the field of family welfare and the program committee feels most fortunate in being able to have her participate in this meeting.

Mary Combs, director of social work, Brooklyn Hospital, Brooklyn, N. Y., is chairman of the section and Helen Beckley, executive secretary, American Association of Hospital Social Workers, Chicago, is the secretary.

On Tuesday morning, October 11, in Committee Room 2, Edith Baker, director of social work, Barnes Hospital, St. Louis, will conduct a round table on records. It is hoped that Gertrude Tennant, social service department, Mayo Clinic, Rochester, Minn., and Ruth Emerson will participate in the discussion. Those who are interested in medical social records will not want to miss this.

Janet Schoenfeld, director of social work, Michael Reese Hospital, Chicago, will conduct a round table on Wednesday morning October 12, in Committee Room 3. The subject will be “Factors of Concern in the Medical, Psychiatric and Social Treatment of the Cholera Child.” This subject will be of interest to other than hospital social workers and a cordial invitation is extended to all who wish to hear this subject discussed.

Wednesday evening the hospital social workers are meeting at dinner with the Minneapolis Social Service Club. It is hoped that this dinner can be held in the new Social Agencies Building, but the definite place of meeting will be announced later.

A round table on “The Hospital as a Community Agency” will be held in Committee Room 2, on Thursday morning, October 13. The name of the leader will be announced later. Social workers as well as others are keenly interested in this subject and the meeting will be an interesting one.

There will be an exhibit of material on social work in hospitals and dispensaries in the association's booth on the lower floor. Margaret Shedd, social worker, Mayo Clinic, Rochester, Minn., is in charge of the exhibit. Reprints of interesting articles and copies of records entered in the recent prize case competition will be available there. An information service will be maintained there daily during the convention.

The president of the association, Mrs. Charles W. Webb, director of social service, Lakeside Hospital, Cleveland, and members of the executive committee will be glad to meet persons interested in social work in hospitals in conference. Those persons wishing to arrange personal conferences should make arrangements at the information desk of the association in the exhibit booth. Any one wishing to arrange for a conference in advance may do so by writing to the American Association of Hospital Social Workers, 18 East Division Street, Chicago, as soon as possible. The secretary will arrange an appointment with the desired member of the executive committee.

Railroad certificates will be sent on application to the national headquarters, 18 East Division Street, Chicago. All visiting delegates are cordially invited to spend Saturday, October 8, in Chicago. Janet Schoenfeld, a representative of the Illinois district of the association, will be pleased to help visitors in planning their day in Chicago.

The headquarters office will be glad to arrange for railroad reservations out of Chicago over the special train to Minneapolis via Rochester, for those who request them to do so.

ADDITIONAL GIFT TO WASHINGTON UNIVERSITY ANNOUNCED

The medical school of Washington University, St. Louis, Mo., has received a gift of \$500,000 to the endowment fund from the General Education Board, New York, and Robert S. Brookings, president of the university corporation, to reimburse the university for expenditures on the affiliated Barnes and Children's Hospitals. The total gifts from the General Education Board to the medical school now amount to about \$5,000,000.

Two "Canada Dry" plants are always open for your inspection

At the Annual Convention of the Hospital Association "Canada Dry" and Sumoro Orange will have an interesting and instructive display. Look for booths 268 and 269.

This fine old ginger ale has become deservedly popular in this country these last few years. Its delicate mellow flavor, so free from harshness and "back bite," has made "Canada Dry" a famous and an honored name wherever beverages are served.

We are proud of that reputation—proud of the people and the methods that have earned it. Into our two plants at New York and Chicago has gone every scientific device that will in any way enable us to maintain the unvarying quality of "Canada Dry." Each of the plants is served by men of wide experience—faithful associates of this company for ten, fifteen, twenty years.

The next time your duties call you near Hudson, N. Y., or Chicago, stop a bit at the home of "Canada Dry." An explanation of the processes in the manufacture of this ginger ale would prove interesting, we know.



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CLINICS TO BE FEATURED AT CHILDREN'S HOSPITAL ASSOCIATION MEETING

SEVERAL speakers of national and international fame and a program so planned that each subject has a definite relation to the other has been announced by the Children's Hospital Association of America, which will meet October 12 and 13 in connection with the annual conference of the American Hospital Association.

The first session will be called to order by President Robert E. Neff, director, University of Indiana Hospitals, Indianapolis, at nine o'clock on Wednesday morning in Meeting Hall A. Greetings from the American Hospital Association will be presented by Dr. R. G. Brodrick, president, and by Dr. Joseph C. Doane, president-elect, of the American Hospital Association.

Dr. O. W. Rowe, Duluth, Minn., will read the first paper and has taken as his subject, "The Relation of the General Practitioner to the Children's Hospital." No discussion will be heard at this time but following the next paper, "The Practical Application of Immunology to Preventive Medicine in a Children's Hospital," presented by Dr. Winford P. Larson, department of bacteriology and immunology, University of Minnesota, Minneapolis, discussions will be opened on both subjects.

Mary E. Murphy, director, Elizabeth McCormick Memorial Fund, Chicago, will read the next paper which is



Robert E. Neff, president

entitled "Health Teaching in a Children's Hospital." Dr. Max Seham, assistant professor of pediatrics, University of Minnesota, will open the discussion on Miss Murphy's paper. The last paper of the first session will be "The Organization of the Medical Staff in a Children's Hospital," by Dr. Isaac A. Abt, professor of pediatrics, North-

western University, Chicago. His paper will be discussed by Dr. Jesse R. Gerstley, Chicago.

There will be a change of meeting place between this session and the one following on Wednesday afternoon. At two o'clock in Meeting Hall C, President Neff will again open the meeting with a paper by Dr. M. G. Peterman, Milwaukee Children's Hospital, Milwaukee, entitled "The Medical Laboratory in a Children's Hospital." This will be discussed by Dr. Samuel Amberg, department of pediatrics, Mayo Clinic, Rochester, Minn. Dr. Joseph Brenne- man, Children's Memorial Hospital, Chicago, will present the next paper on the subject "The Out-Patient Department of a Children's Hospital." Dr. J. T. Christison, medical director, Wilder Out-Patient Department, St. Paul, Minn., will discuss it. The last paper of the Wednesday afternoon session will be "Pediatric Nursing" read by Lillie A. M. Bennett, superintendent of nurses, Milwaukee Children's Hospital, Milwaukee. One of the features of the meeting will then be presented when President Neff will conduct a round table at which time problems embracing architectural ideas and essential requirements in the construction of a children's hospital will be brought up.

From ten o'clock in the morning until four o'clock in the afternoon the members of the Children's Hospital Association will participate in especially arranged trips of inspection and clinics at the University of Minnesota Hospital, the Shriners' Orthopedic Hospital, Lymanhurst School, the Gillette State Hospital for Crippled Children, Glen Lake Sanatorium, Oak Terrace, Minn., and the Wilder Out-Patient Department.

The Twin Cities have long been famed for the work that is done there for crippled children and for the excellence of the children's hospitals. It is doubtful if any other similar community has as many advanced ideas to be presented as will be found there, and the members of the association will find a great deal of interest in each of the institutions where clinics will be held.

The committee of local arrangements consists of the following: Dr. Frederick W. Schultz, professor of pediatrics, University of Minnesota, chairman; Paul Fesler, superintendent, University of Minnesota Hospital; Elizabeth McGregor, superintendent, Gillette State Hospital for Crippled Children; Dr. James T. Christison, medical director, Wilder Out-Patient Department and Dr. E. S. Mariette superintendent, Glen Lake Sanatorium.

MASSACHUSETTS INSTITUTES RESEARCH WORK IN PSYCHIATRY

The Massachusetts Department of Mental Diseases has instituted a novel and promising experiment in the field of mental research, the development of which will be watched with considerable interest by psychiatrists, according to a recent *Public Health Report*.

It is planned to make use of the state hospital system in Massachusetts in the scientific study of psychiatry and mental hygiene, and of the development of the epidemiology of mental diseases and mental deficiency. These institutions afford a mass of data which can be readily and economically made available and which, when studied and analyzed, will no doubt add materially to the knowledge of mental diseases that has so far for the most part been contributed by studies of individual cases.

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It is operated by compressed air . . . Attached to wall by two screws . . . Flexible tube permits foot plunger to be moved at will . . . No mechanical parts to get out of order.

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INFANTOL PORTABLE DISPENSER

Economical, Efficient and Sanitary

Economical . . . because it is dispensed from INFANTOL DISPENSERS, supplying just enough with each push. None is wasted; every drop is used.

Efficient . . . because the dispenser is portable, easily moved and always ready for service . . . Easier to use than old-style cake soap.

Sanitary . . . because it is dispensed from a glass container, which protects it from all impurities.



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ST. LOUIS, MO.



MANY SUBJECTS WILL BE DISCUSSED BY OCCUPATIONAL THERAPISTS

AN EXCEPTIONALLY well balanced program has been prepared for the meeting of the American Occupational Therapy Association which will be held in conjunction with the American Hospital Association convention at Minneapolis Auditorium, Minneapolis, Minn., October 10, 11 and 12.

On the Sunday evening preceding the meeting there will be a meeting of the board of management at the Leamington Hotel, which has been chosen for the headquarters of the association during the meeting.

The opening session will be held in Convention Hall B on Monday morning. From 8:30 to 10 a. m., registration will take place and this will be followed by invocation asked by the Rev. Clair E. Ames, president, Federation of Ministers of Minneapolis and pastor of the Fifth Avenue Congregational Church. Dr. Joseph C. Doane, the president elect of the American Hospital Association, will bring greetings from the larger organization and this will be followed by the presidential address delivered by President T. B. Kidner. The next order of business will be an address by Dr. Charles A. Prosser, director, Dunwoody Institute, Minneapolis. The report of the secretary-treasurer, Mrs. Eleanor Clarke Slagle, and the report of the finance committee, given by Mrs. F. W. Rockwell, Philadelphia, will complete this session.

Committee on Research to Report

On Monday afternoon there will be heard the report of the standing committee on research and efficiency which will be given by Marian Clark, Ann Arbor, Mich. The subject of the report will be "Muscle Training by Occupational Treatment in Children's Hospitals."

A paper entitled "The Junior League's Occupational Therapy Work for the Children in Milwaukee" will be read by Mrs. Robert F. Phillips, Curative Workshop Committee, Milwaukee. This will be followed by another paper by Hilda B. Goodman, director, Junior League Curative Workshop, Milwaukee, entitled "Corrective Work for Children." Margaret M. Lison, executive secretary, Wisconsin Association for the Disabled, will lead the discussion. The last paper of the Monday afternoon session will be "When Is Occupation Curative?" read by Ida F. Sands, chief occupational therapist, Philadelphia General Hospital, Philadelphia. It will be discussed by Alice H. Dean, chief occupational therapist, Evanston Hospital, Evanston, Ill. Tea will be served at four o'clock with Mrs. Otto Bradley and Mrs. Lee as hostesses.

On Monday evening in Convention Hall B, the report of the standing committee on publicity and publication will be given by chairman Dr. William R. Dunton Jr., Catonsville, Md. Dorothy Hubbard Kidder, director of occupational therapy, Friends' Hospital, Frankford, Philadelphia, will then read a paper entitled "Occupational Therapy at Friends' Hospital." Another paper entitled "The Psychological Basis of Occupational Therapy" will be given, the speaker to be announced later.

One of the features of this evening's meeting will be the symposium on organization, methods and work in mental hospitals. Four topics will be discussed and each speaker is requested to keep to eight minutes, the leaders of discussion to five and other discussers to four minutes each. The symposium program is as follows:

"The Organization of Occupational Therapy in a Large

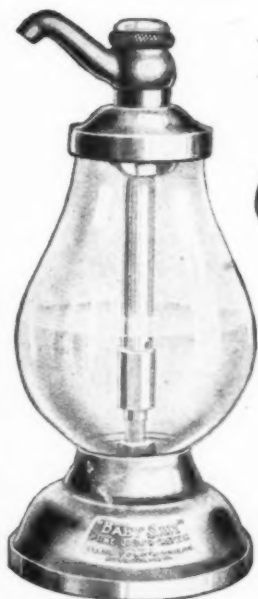
Mental Hospital," Rebecca A. Adams, New Jersey State Hospital, Greystone Park, N. J.; leader of discussion, Mary E. Black, Traverse City State Hospital, Traverse City, Mich.; "Habit Training; Methods and Results," Dr. Charles L. Vaux, Central Islip State Hospital, Central Islip, L. I.; leader of discussion, Mrs. Eleanor Clarke



T. B. Kidner, president

Slagle, director of occupational therapy, State of New York; "Work on the Wards, Methods, Crafts and Equipment," Florence M. Northrup, La Grange, Ill.; leader of discussion, Julia H. Bradley, Oak Park, Ill.; "Work in the Occupational Therapy Center, Methods, Crafts and Equipment," Mrs. Henrietta G. Price, Sheppard and Enoch Pratt Hospital, Towson, Md.; leader of discussion to be announced; "The Pre-Industrial Shop: Problems, Organization and Methods," Harriett A. Robeson, Kings Park Hospital, Kings Park, L. I.; leader of discussion, Mary E. Shanklin, Chicago.

On Tuesday morning Harriett A. Robeson will present the report of the committee on installations and advice, which will be entitled "The Analysis of Crafts Used in Occupational Therapy." The rest of the morning will be given over to the discussion of problems in tuberculosis sanatoriums, with the following speakers and topics: "Occupational Therapy in a Tuberculosis Sanatorium and its Relation to After Care, Vocational Training and Placement," Dr. B. E. Hedding, Wisconsin Anti-Tuberculosis Association, Milwaukee; leader of discussion, R. R. Rossell, Hennepin County Tuberculosis Association, Minneapolis; "Medical, General and Social Considerations with Some Historical Reminiscences," Dr. Glenford T. Bellis, superintendent and medical director, Muirdale Sanato-



Patents Pending

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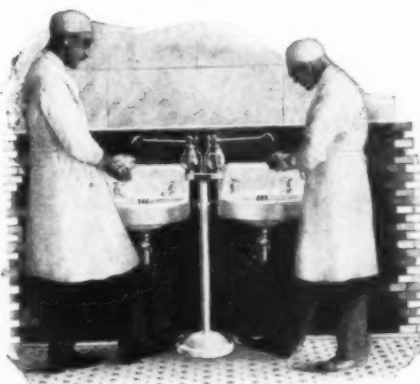
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Don't Buy Imitations*



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*America's Favorite Surgical
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Will save from 50% to 75% of the alcohol formerly used in the operating room. Operated by foot pedal.

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American Hospital Association **Booth Nos. 263-271-272**

rium, Wauwatosa, Wis.; "Bedside, Ward, Porch and Shop Methods," Irene Grant, Muirdale Sanatorium, Wauwatosa, Wis.; "Occupational Therapy at Glen Lake Sanatorium" (in two parts): "Procedure, Methods and Scope," by Mrs. Lydia Rowe, director of occupational therapy, Glen Lake Sanatorium, Oak Terrace, Minn., and "The Next Step," by Dr. E. S. Mariette, superintendent and medical director, Glen Lake Sanatorium, Oak Terrace, Minn.

On Tuesday afternoon occupational therapy systems in the hospitals of the United States Veterans' Bureau will be discussed. The subject will be introduced by Dr. B. W. Carr, chief of occupational therapy and physiotherapy, U. S. Veterans' Bureau, Washington, D. C., and the guests of honor at this session will be Dr. H. B. Fralic, Fort Snelling, Minn. and Dr. H. D. Luse, Minneapolis. The papers are as follows: "Occupational Therapy in a General Hospital," Anne M. Coe, Lake City, Fla.; "Rags," Eva Louise Zoller, Boise, Idaho; discussion opened by Esther C. Macomber, Fort Snelling, Minn.; "Occupational Therapy with Tuberculosis Patients," Emma L. Baker, Minneapolis; "Occupational Therapy with the Ex-Service Man," Eunice M. Cates, Aspinwall, Pa.; "Relating Occupational Therapy to Rehabilitation," Martha Jenkins, Oteen, N. C.; "Occupational Therapy in the Treatment of Those Mentally Disabled," Dr. Frank Albert Davis, Bronx, N. Y.; "Therapeutic Occupations for Mental Patients," Bonnie E. Malott, Gulfport, Miss.; "Administration of Occupational Therapy with Psychoneurotic and Psychotic Patients," Lee R. Payne, Perry Point, Md.; discussion opened by Arthur C. A. Kolhoff, North Chicago, Ill.; "Occupational Therapy in Relation to Agriculture," Harry J. Kefauver, Washington, D. C.; discussion opened by Clyde H. Taylor, Camp Custer, Mich.

The annual reception to members and friends will be held Tuesday evening at Glen Lake Sanatorium, by invitation of Dr. Mariette and the sanatorium staff. Buses will leave the Hotel Leamington at 7:30 p. m.

Wednesday's Sessions

The Wednesday morning session will consist of a report of the committee on teaching methods, divided into two subjects, "Practice Training; Methods of Organization and Supervision" and "General Report and Recommendations." Mrs. Carl Henry Davis, Milwaukee, will make the report for the committee and the discussion will be opened by Alberta Montgomery, Walter Reed General Hospital, Washington, D. C. The remainder of the program is as follows: "What Should a Hospital Expect from Pupil Workers?" Dr. William A. Bryan, Worcester State Hospital, Worcester, Mass.; discussion opened by Louis J. Haas, Bloomingdale Hospital, White Plains, N. Y.; "What Should a Training School Expect from a Hospital for Its Pupils Who are Taking a Period of Practice Training?" Geraldine R. Lermitt, St. Louis School of Occupational Therapy, St. Louis; Discussion opened by Marjorie B. Greene, Boston School of Occupational Therapy, Boston.

On Wednesday afternoon Dr. George R. Dunn, Minneapolis, will speak on "Occupational Therapy in Industrial Accident Cases," and T. Norman Dean, Ontario Workmen's Compensation Board, Toronto, will speak on "The Value of Curative Work in Workmen's Compensation Cases." Oscar M. Sullivan, director of re-education of disabled persons, State Department of Education, St. Paul, Minn., will lead the discussion. The session will end with a business meeting and the election of officers.

The association has an invitation from the Wisconsin Association to visit Milwaukee.

HOSPITAL DIETETIC COUNCIL TO MEET WITH A. H. A.

Motion pictures of the digestive apparatus, talks on metabolic rates, a study of the biochemist's point of view on pernicious anemia, a series of demonstrations in teaching dietetics and several visits to nearby institutions will feature the program of the Hospital Dietetic Council when it meets with the American Hospital Association at Minneapolis, Minn. The first session will be opened on Tuesday morning, October 11, and the meetings last through Thursday.

Two speakers will discuss metabolic rates on Tuesday morning and motion pictures will be shown to illustrate the points brought up. In the afternoon a study of food costs in hospitals will be presented. This discussion has been divided into three parts: dietary needs that can be satisfied only by certain vegetables and fruits, which of these essential fruits and vegetables the hospital can best afford to include in its dietary, and how the additional labor necessary to prepare these vegetables and fruits can best be managed, both as to equipment and as to personnel. In conjunction with this session there will be exhibited several pieces of equipment for examination.

On Wednesday morning a study of pernicious anemia will be held. This will consume the entire morning session and in the afternoon the council will meet with the American Hospital Association when speakers on hospital cafeterias, education and recreation, and irradiated foods will be heard. Following this afternoon session the members will attend a tea given in their honor at the University Farm School.

The hotel dietitian, the need of hotel standards for hospital food service and the standardization of portions for regulating the amounts of prepared food supplies will all be discussed on Wednesday evening by speakers from both the hotel and the hospital field.

A series of demonstrations in teaching have been planned for Thursday morning. The subdivisions of the subject are as follows: Teaching the medical student how the diabetic diet is chosen according to the doctor's prescription; teaching the obesity patient her post-hospital diet; teaching the patient from the gastric clinic, who is also preparing a menu for the entire family; and teaching the student nurse her own need for an ample supply of calcium.

In the afternoon there will be a round table on personnel service in the hospital, papers on new and tested recipes, and other subjects.

The closing session of the council will be held Thursday evening, with a metabolic round table in which various dietitians will submit case experience on diabetes and pernicious anemia.

ILLINOIS STATE HEALTH DEPARTMENT SPONSORS NEW LABORATORY

Under the supervision of the Illinois State Health Department a new laboratory for diagnosis was recently opened in the Illinois Research Hospital Building, 1817 West Polk Street, Chicago. Dr. Lloyd Arnold, professor of bacteriology and preventive medicine, University of Illinois College of Medicine, Chicago, is in charge. The laboratory services will be free to physicians and other citizens of the state. Rooms in the basement have been set aside for this work. There will be a full-time staff of bacteriologists, serologists and chemists.

Why the GOLDEN rather than the PALE DRY is recommended in the diet of the sick

DIFFICULT diet problems are often made easier by the use of Ginger Ale—something physicians and nurses have known for years.



That is why it is favored very generally by those who use Ginger Ale in cases of stomach disorder and during convalescence.

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Fine Ginger Ales, both of them—but the GOLDEN is more effective in the diet of the sick.



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PRACTICAL DEMONSTRATIONS WILL FEATURE A. C. OF S. PROGRAM

THE following program has been arranged for the hospital standardization conference of the Clinical congress of the American College of Surgeons to be held in Detroit, October 3, 4, 5 and 6:

On Monday morning at ten o'clock the first session will be called to order by Dr. W. W. Chipman, Montreal, president of the college, in Orchestra Hall. Following Dr. Chipman's address, Dr. T. K. Gruber, superintendent, Detroit General Hospital, Detroit, and chairman of the Detroit and Wayne County Hospitals Council, will deliver an address of welcome. This will be followed by the presentation of the tenth annual report of the hospital standardization movement which will be given by Dr. Franklin H. Martin, director general of the college.

"The Application of Hospital Standardization Principles to U. S. Veterans' Hospitals" is the title of the paper that will be read by Dr. B. W. Black, medical director of the United States Veterans' Bureau, Washington, D. C. The second paper will be given by John A. Lapp, Chicago, professor of sociology, Marquette University, Milwaukee, Wis., the subject matter being "The Right of a Hospital to Choose Its Staff." The third paper on the program is entitled "The Adjudicating Aspects of the Staff Conference," by Judge Harold M. Stephens, Salt Lake City, Utah. "Hospital Charges and Costs" is the title of the next paper, to be read by John A. McNamara, executive editor, *THE MODERN HOSPITAL*, Chicago, and this will be followed by "The Care of the Patient of Moderate Means," by Dr. Bert W. Caldwell, superintendent, Gordon Keller Memorial Hospital, Tampa, Fla. Robert Jolly, superintendent, Baptist Hospital, Houston, Tex., and president of the American Protestant Hospital Association will lead the discussion.

Father Moulinier to Speak

The second session will be called to order by Dr. Chipman at two o'clock on Monday. At this time the Rev. C. B. Moulinier, S. J., president, Catholic Hospital Association, Milwaukee, Wis., will speak on "The Art of Nursing," and Dr. George W. Kosmak, editor, the *American Journal of Obstetrics and Gynecology*, New York, will read a paper on "Fundamental Training for Nurses."

Dr. May Ayres Burgess, director of the study, Committee on Grading of Nursing Schools, New York, will be the next speaker. Her talk is entitled "Facts and Findings Pertaining to Nursing, Gleaned from a Survey of the Hospital and Private Duty Nursing Field, from the Standpoint of the Patient, the Doctor and the Nurse."

After these papers the remainder of the session will be given to a round table conference on nursing problems, conducted by Dr. William H. Walsh, executive secretary, American Hospital Association, Chicago. The following topics will be discussed: "Preliminary Educational Requirements," Shirley Titus, R.N., director of nursing, University of Michigan Hospital, Ann Arbor, Mich.; "Nursing Curriculum," Laura R. Logan, R.N., dean, Illinois Training School for Nurses, Chicago; "Group Nursing," Janet Geister, R.N., director, American Nurses' Association, New York; "Central Nurses' Registries," Minnie H. Ahrens, R.N., director, Chicago Nurses' Club and Directory, Chicago; "State Requirements," Adda Eldredge, R.N., director, Bureau of Nursing Education, State Board of Health of Wisconsin, Madison, Wis., and "Cooperation

Between the Medical and Nursing Professions," Jane Van De Vrede, R.N., State Board of Nurse Examiners, Atlanta, Georgia.

The third session will be called to order in the Statler Hotel, Tuesday morning at ten o'clock, with Louis J. McKenney, chairman of the board of trustees, Highland Park General Hospital, Highland Park, Mich., presiding. The entire session will be for the benefit of the trustees and the following program has been arranged:

Trustee Gets Prominence

"Basic Considerations in Selecting Hospital Trustees," Dr. Stewart Hamilton, director, Harper Hospital, Detroit; "What the Trustee Should Know About a Hospital and How Best to Secure This Information," Robert Irwin, vice-president, board of trustees, Butterworth Hospital, Grand Rapids, Mich.; "Function of the Board of Trustees," C. H. Marr, chairman of the board of trustees, Wyandotte General Hospital, Wyandotte, Mich.; Round Table Conference, conducted by Dr. W. L. Babcock, Director, Grace Hospital, Detroit, with the general theme "Relations of the Board of Trustees to the Superintendent, the Superintendent of Nurses and to the Medical Staff." Charles F. Neergaard, trustee, Carson C. Peck Memorial Hospital, Brooklyn, N. Y., will speak on the first part of the subject, Mary C. Wheeler, general secretary, Michigan State Nurses' Association, Detroit, on the second part, and Samuel Jackson, chairman of the board of trustees, Tacoma General Hospital, Tacoma, Wash., on the last topic.

Those who will lead the discussion on all of the nursing subjects will be Newton E. Davis, corresponding secretary, Board of Hospitals, Homes and Deaconess Work of the Methodist Episcopal Church, Chicago, and A. C. Galbraith, superintendent, Western Hospital, Toronto, Ont.

The fourth session will be called to order at two o'clock at the Statler Hotel and the following papers will be presented.

"The Compilation of Statistics as a Guide to Medical Efficiency," Dr. Charles Eaton Phillips, attending surgeon, Los Angeles General Hospital, Los Angeles, Calif.; "Medico-Legal Responsibilities of Hospitals," Judge Harold M. Stephens, Salt Lake City, Utah; "The Emergency Department in the Hospital," (illustrated), Dr. Phillip H. Kreuscher, professor of clinical orthopedic surgery, Loyola University School of Medicine, Chicago; "Advantages of Autopsies," Dr. Bowman C. Crowell, associate director, American College of Surgeons, and Director of Clinical Research, Chicago; "Means of Securing Autopsies," Dr. Ralph G. Mills, pathologist, Mayo Foundation, Rochester, Minn.; "A Minimum Standard for Physical Therapy" (illustrated), Dr. John S. Coulter, assistant professor of physical therapy, Northwestern University School of Medicine, Chicago; general discussion opened by Dr. A. G. Barrett, president, medical committee, West Baltimore General Hospital, West Baltimore, Md., and Dr. Edgar A. Bockock, superintendent, Colorado General Hospital, Denver.

On Wednesday morning Dr. George E. Frothingham, chief of the department of ophthalmology, rhinology and otolaryngology, Harper Hospital, Detroit, will open the fifth session at the Hotel Statler. Following is the program:



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"Presentation of a Minimum Standard for General Hospitals Caring for Eye, Ear, Nose and Throat Patients," Dr. Joseph C. Beck, associate professor of otolaryngology, University of Illinois College of Medicine, Chicago; "Organization," Dr. Thomas E. Carmody, professor of oral surgery and rhinology, University of Denver Dental Department, Denver, Colo.; "Personnel," Dr. W. W. Pearson, otolaryngologist, Congregational, Mercy and Lutheran Hospitals, Des Moines, Ia.; "Records," Dr. Perry G. Goldsmith, professor of otolaryngology, University of Toronto Faculty of Medicine, Toronto; "Staff Conference," Dr. Walter H. Snyder, ophthalmologist and chief of staff, Flower Hospital, New York; "Instruction of Nurses and Interns," Dr. Austin A. Hayden, ophthalmologist and otolaryngologist, St. Joseph's Hospital, Chicago.

On Wednesday afternoon there will be demonstrations in hospital planning, construction, equipment, organization and administration, under the auspices of the Detroit and Ann Arbor Hospitals.

On Thursday morning Dr. Malcolm T. MacEachern, associate director, American College of Surgeons and director of hospital activities, Chicago, will conduct a round table entitled "Your Everyday Problems." The following will participate:

Demonstrations Will Be Held at Hospitals

"Factors Determining Hospital Efficiency," Dr. George B. Landers, superintendent, Highland Hospital, Rochester, N. Y.; "Factors Influencing Average Days' Stay of Patients in Hospitals," John E. Ransom, superintendent, Toledo Hospital, Toledo, Ohio; "Ideal Organization of the Medical Staff in an Open Hospital," Dr. E. W. Williamson, assistant to the director of hospital activities, American College of Surgeons, Chicago; "Staff Conference Procedure," C. S. Pitcher, superintendent, Presbyterian Hospital, Philadelphia; "Minimum Standard for Maternity Service in General Hospitals," Dr. Roy C. Kingswood, obstetrician and gynecologist, Jefferson Clinic and Diagnostic Hospital, Detroit; "Status, Functions and Relations of the Dietitian to the Hospital Administration," S. Margaret Gillam, director, dietetics and housekeeping, University of Michigan Hospital, Ann Arbor, Mich.; "Standardization of Ward Supplies and Routine," E. Muriel McKee, superintendent, Brantford General Hospital, Brantford, Ont.; "Educational Publicity for Hospitals," Matthew O. Foley, managing editor, *Hospital Management*, Chicago.

The meeting will end on Thursday afternoon with demonstrations of hospital planning, construction, equipment, organization and administration, under the auspices of the Detroit and Ann Arbor Hospitals.

ROCHESTER TO ENTERTAIN DELEGATES

The following plans for the reception of visitors to Rochester, Minn., who are expected to visit that city on October 9, have been announced by H. J. Harwick, Mayo Clinic, Rochester, chairman of the reception committee:

"Two representatives of our local committee will board the Rochester special train in Chicago and ask each delegate which phase of the Rochester activities interests him. Each delegate will then be given some mark of identification.

"Upon their arrival at Rochester the delegates will be met by the reception committee and grouped according to their marks of identification. They will then be taken to the various institutions in Rochester in which they are interested.

"Following this they will be entertained at the following luncheons: St. Mary's Hospital, 200; Kahler Corporation, 200; Rochester State Hospital, 200; and Rochester Diet Kitchen, 50 delegates.

"After luncheon all groups will assemble in the amphitheater of the nurses' home, St. Mary's Hospital, at 2:30 p. m. where the following thirty-minute program will be given: address of welcome, Dr. Charles H. Mayo; "The Mayo Clinic," Dr. William J. Mayo; and "The Mayo Foundation," Dr. L. B. Wilson."

Mr. Harwick states that these plans are tentative and some changes may be made.

HOSPITAL AND INSTITUTIONAL TEXTILES TO BE STANDARDIZED

The division of simplified practice of the U. S. Department of Commerce, Washington, D. C., has issued the report of the general conference on hospital and institutional textiles, held in Washington, June 10, 1927.

Manufacturers, distributors and consumers were represented at this conference, which was based on a careful study of conditions and requirements. Modifications of the proposed simplified schedule will be made as future trends in the textile industry may render desirable. The conference appointed a standing committee who will be glad to receive and consider comments on the report. Margaret Rogers, superintendent, St. Luke's Hospital, St. Paul, Minn., is chairman of the committee.

The schedule recommended by the department of commerce through the bureau of standards, as a result of the conference, is as follows:

Sizes of Textiles for Adult Beds

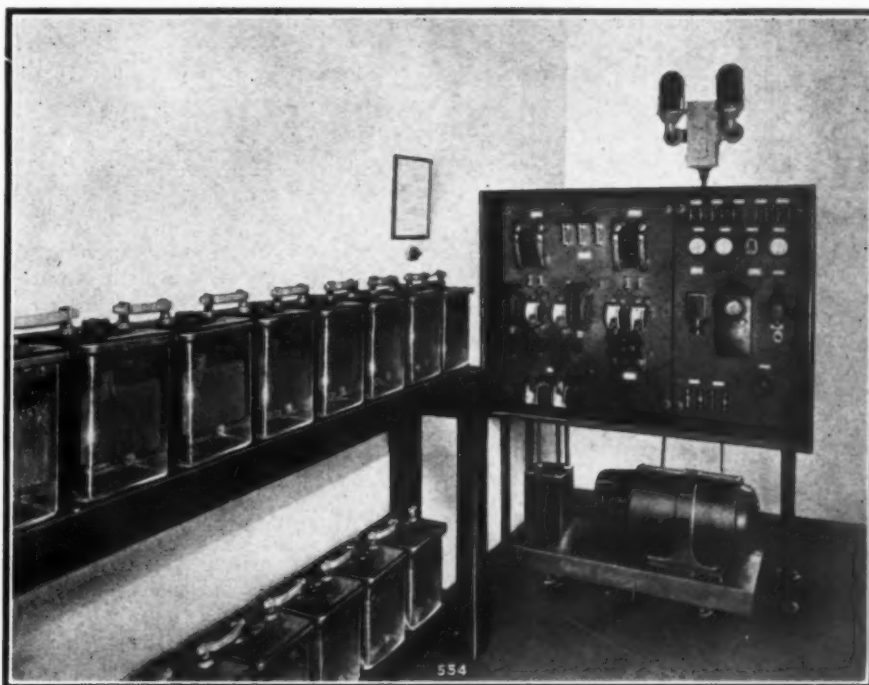
Item	Sizes (Inches)	Torn or Finished Size	Depth of Hem	Present Standard Packing (per case)
Bed Pads	36x36 36x72 36x76	Finished	
Pillow Cases	42x36 45x36	Torn	3 inches	50 doz.
Sheets	63x99 63x108 72x99 72x108	Torn	Top: 3 inches Bottom: 1 inch	20 doz.
Drawsheets	45x72 54x72	Torn	Top: 1 inch Bottom: 1 inch	20 doz.
Spreads	63x90 72x90	Cut or torn	¾ inch	50 & 100
Bureau Scarfs	18x45 18 wide by bolt	Cut		5 doz.
Towels (Bath)	18x36 22x44	Finished		50 doz. 50 & 25 doz.
Towels (Face and Hand)	14x20 16x32 18x36 18 wide by bolt	Finished		200 doz. 100 doz. 100 doz. 40/50 yds. per piece 2000 yds. per case

Sizes of Textiles for Crib and Bassinets

Item	Sizes (Inches)	Torn or Finished Size	Present Standard Packing (per case)
Sheets			
Crib	45x64—54x90	Torn	20 doz.
Bassinet	36 wide sheeting by bolt		
Spreads			
Crib	45x60—54x90	Cut	50 & 100
Bed Pads			
Crib	18x18	Finished	
Bassinet	18x18	Finished	

These recommendations are to be effective from October 1, 1927, subject to annual revision by the standing committee.

The full automatic Roth Emergency Lighting System, Model 7286, not only provides instant and automatic service in an emergency, but also maintains itself in constant readiness without relying upon the human element for attention.



**The priceless security of
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Hospitals already using the Roth Emergency Lighting System have found that an emergency is not needed to demonstrate the value of this perfect protection. The absolute security against sudden darkness gives both staff and patients an added confidence in the institution.

When the emergency arises, when some distant, unavoidable accident cuts off your lights, nobody need do anything unusual. The Roth System is instantaneous and automatic, picking up the load with hardly a flicker of the lights. Patients never know that the regular power supply has failed. The surgeon never pauses and his at-

tention is not distracted by the knowledge that his light is on the emergency system. Only the engineer or superintendent knows that the Roth System is functioning on the emergency source of power.

Prepare now for the unexpected, demoralizing darkness that may be caused by some condition wholly out of your control. Send for the Roth bulletins describing the operation of the Emergency Lighting System. Our engineering staff will gladly show you what has been done in other hospitals and demonstrate the value of this protection. The investment required is a moderate one.

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NEWS OF THE MONTH

AMERICA CHOSEN FOR FIRST INTERNATIONAL HOSPITAL MEETING

Paris, September 19 (by special cable). The United States was selected as the meeting place for the first international meeting of hospital executives to be held in June, 1929. The city at which the convention will be held has not as yet been chosen and the choice was left in the hands of the committee from America, by the delegates to the meeting from the European countries.

This will be the first time that an official meeting between American and European hospital executives has been held, and it is expected that there will be many visitors to the meeting from Europe. The British Hospitals Association has on several occasions expressed its desire to attend the hospital meetings held in this country by the American College of Surgeons and by the American Hospital Association.

Most of the European countries were represented at the meeting in Paris and they all voiced their praise of American hospitals and their anxiety to visit them. Most of those present have become familiar with institutions in the United States and Canada by reading the hospital publications published in America. The American delegates to the meeting were Dr. Joseph C. Doane, president-elect, American Hospital Association, Philadelphia, and E. H. Lewinski-Corwin, United Hospital Fund, New York. Capt. J. E. Stone, St. Thomas' Hospital, London, secretary of the Hospital Officers Association of Great Britain, represented Great Britain.

PLANS COMPLETE FOR 1927 CLINICAL CONGRESS OF PHYSICAL THERAPY

The American College of Physical Therapy announces that plans have been completed for its 1927 clinical congress of physical therapy and sixth annual meeting, to be held at the Hotel Sherman, Chicago, October 31 to November 5.

The first three days of the congress are to be devoted to a school of instruction. For this purpose prominent clinicians and teachers have been selected and intensive fundamental and clinical training will be given. There will be one day of sectional meetings, the following distinct sections being represented: medicine, diagnosis, pediatrics and endocrinology; surgery, gynecology, urology, orthopedics; eye, ear, nose, throat and oral surgery.

The fifth day of the congress will be devoted to a joint session. Numerous special addresses by some of the foremost leaders in medicine will be offered. The closing day will be given over to hospital and dispensary clinics.

Physical therapy has made rapid strides in the past few years and a gathering such as this is of vital interest to every practitioner and specialist. The program in itself is attractive but additional features in scientific and commercial exhibits, demonstration clinics and small

group conferences will help to make this congress outstanding.

Physicians in good standing in their county societies are eligible to attend as are also technicians and physicians' assistants properly vouched for.

Those who wish to attend the congress are urged to enroll by mail as early as possible. The fee for the instruction classes is \$10, payable by all whether fellows of the college or not. Non-fellows of the college must pay in addition a registration fee to the assembly of \$5. Copies of the program and further information may be obtained from the chairman of the convention committee, American College of Physical Therapy, 30 North Michigan Avenue, Chicago.

DR. GOLDWATER TO VISIT ENGLAND

King Edward's Hospital Fund for London has appointed a special committee of inquiry to be called the pay beds committee to inquire into and report upon the question of hospital accommodation in London for persons prepared to pay more than ordinary voluntary hospital patients. Dr. S. S. Goldwater, director, Mount Sinai, New York, will visit England in October to give the voluntary hospitals of London and England, through the Fund the benefit of the experience of the United States in the construction and maintenance of pay or private beds.

ZOOLOGICAL HOSPITAL OFFERS FACILITIES FOR RESEARCH WORK

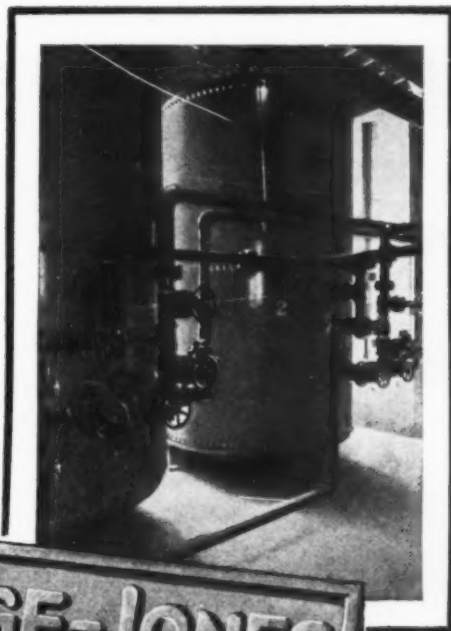
San Diego, Calif., has recently acquired a Zoological Hospital and Research Institute, the gift of Ellen C. Scripps. The institution is sponsored by the Zoological Society of San Diego and the recent dedication ceremonies were attended by about 135 physicians and other scientists. Physicians interested in research may avail themselves of its facilities and no charge will be made except for material used or broken.

The building, which is in a large zoological garden, will be a hospital for animals in the zoo, and pathologic tissues from zoos in other parts of the country will be collected so that animal diseases may be studied. There are eleven small laboratories, each equipped for special work, a roentgen ray and dark room, a library, a general laboratory, technicians' laboratory offices, a morgue and a photomicrographic outfit. Here biologists and research workers will find the equipment for research work, and college professors and advanced students will have an opportunity to continue studies when in California.

DR. HOWARD OF ROCHESTER DIES

Dr. Eugene H. Howard, for forty-two years superintendent of Rochester State Hospital, Rochester, N. Y., died recently of injuries received in an automobile accident. Dr. Howard was seventy-seven years of age and as superintendent of the state hospital over a long period he was widely known throughout the state.

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The "key" machine that operates at the lowest possible cost is the Paige-Jones Upward Flow Zeolite Water Softener.

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News of the Month

FIRST STATE CANCER HOSPITAL OPENED

The Pondville Hospital, a hospital for cancer in all stages, to be operated by the State of Massachusetts, was recently opened at Norfolk, Mass. The grounds comprise some 1200 acres upon which there are eight buildings. The buildings have been provided with modern surgical equipment and roentgen ray apparatus and there will soon be radium for the treatment of cases of cancer in all stages.

The hospital provides a nucleus around which has been constructed a comprehensive plan to provide the best in the way of diagnosis and treatment. The number of beds will be ninety to ninety-five.

Twelve clinics at Lowell, Lynn, Newton, Springfield, Worcester, Brockton, Fall River, Fitchburg, Greenfield, Lawrence, New Bedford and North Adams, will be operated in conjunction with the hospital.

The establishment of this institution is an integral part of a program framed at the instigation of the legislature by the commissioner of public health and his advisers, looking toward a reduction in the cancer death rate of the state, says the *Public Health Nurse*. It is the first time in history that a state health department has been charged with the control of a chronic disease which is recognized as non-communicable and the causes of which are not known. Those who are responsible for this program base their confidence of success upon three main factors:

The giving of correct information in understandable form to the public, regarding the early signs of cancer and precancerous conditions.

The affording of adequate diagnostic and treatment facilities for those who have discovered their need of them.

The acquiring of more knowledge as to the environmental, dietetic and biologic factors contributing to the prevalence of the disease in Massachusetts.

GIFT TO AID CANCER RESEARCH

The Memorial Hospital, New York, has received a gift of \$60,000 a year for five years from John D. Rockefeller, Jr., to aid in cancer research and in the education of specialists who can diagnose and treat cancer in its earliest stages. The money is to be used for laboratory and clinical research into the causes of cancer; for the education of specialists, so that cancer may be diagnosed and treated in its earliest stages, and for the improvement of the nursing staff of the Memorial Hospital.

CONVALESCENT HOME FOR TUBERCULOSIS PATIENTS PLANNED

Plans to establish a convalescent home for tuberculosis patients released from Glen Lake Sanatorium, Oak Terrace, Minn., and from other sanatoriums, while they are seeking positions and getting on their feet financially, have been announced by the Hennepin County Tuberculosis Association. A campaign for funds to make the home possible has been launched. The association already has \$3,000 and with an additional \$4,000 can open a home where patients can have a place to recuperate.

A building that will accommodate fifteen or twenty persons is contemplated.

CRIPPLED CHILDREN'S HOSPITAL TO BE BUILT ON UNIVERSITY CAMPUS

It is expected that construction will start this Fall on the William Henry Eustis Hospital for Crippled Children to be built on the campus of the University of Minnesota, Minneapolis. The entire project will cost between five and six hundred thousand dollars and the work will be in three sections, including a hospital building, an out-patient department and a connection between the new plant and the present university hospital building.

Funds for the crippled children's hospital have been provided entirely by William Henry Eustis, a former mayor of Minneapolis, who has also established a trust fund to provide for the maintenance of the hospital. The out-patient department will be financed by state funds already appropriated.

NEEDS OF THE CHRONIC PATIENT TO BE STUDIED

During the past year there has been organized in connection with the Welfare Council of New York City, a public health nursing section, says the *Public Health Nurse*. The Welfare Council, through its research bureau, is ready to assist in such studies recommended by the various sections as seem to them of general importance. Since the care of the chronic patient is a problem which is closely related to a number of public health nursing organizations, the public health nursing section recommended to the council that a plan be worked out to determine the nature and extent of this problem.

It is hoped that policies may be decided upon and facilities provided which will more adequately meet the needs in this field. The general committee on the care of the chronic sick which is now guiding the study to be made in the Fall, consists of representatives from the following sections of the welfare council: hospitals; the care of the aged; convalescent care; medical social service; family welfare; public health nursing section.

A somewhat similar project, a study of hospital and home care of the chronic sick, has just been started in Boston.

NEW COMMUNITY HOSPITAL FOR KANE

A community hospital of sixty-bed capacity is being constructed at Kane, Pa. This will be a brick and limestone building with every modern facility for the treatment of the sick. The architect is Lafayette A. Goldstone, New York, and the consultant is Dr. Joseph C. Doane, Philadelphia.

THE I. C. N. TO MEET IN MONTREAL

It is announced that the 1929 meeting of the International Council of Nurses will be held in Montreal, Que. The council this year held an interim conference in Geneva, Switzerland, in July, when 784 nurses were in attendance, representing thirty-four countries.

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Personals

DR. JOHN A. LAPP, Chicago, retiring president of the National Conference of Social Work and widely known sociologist, has been appointed professor of sociology at Marquette University, Milwaukee, Wis.

DR. CHARLES A. DREW, who has been superintendent of the City Hospital, Worcester, Mass., for the past eighteen years, is to retire from active hospital work and has tendered his resignation to take effect November 1.

DR. J. R. HOWELL has been appointed physician in charge of the Aiken County Hospital, Aiken, S. C.

DR. EDWIN J. KEHOE, formerly of Dayton, Ohio, has recently accepted the position of superintendent and medical director of the Livingston County Sanatorium, Pontiac, Ill.

DR. EARL B. MILLER recently resigned as medical director of the Elm Grove Sanatorium, Bushnell, Ill., to accept a similar position at Hillcrest, Adams County Tuberculosis Sanatorium, Quincy, Ill.

DR. LOUIS WENDER has been appointed medical director of the new psychiatric hospital to be known as the Hastings Hillside Hospital, which was recently opened by the Jewish Mental Health Society of New York at Hastings-on-Hudson, N. Y.

PAULINE MARTIGNONI, R.N., formerly superintendent of the American Hospital, Chicago, now resides at 4019 Clarendon Avenue, Chicago.

ADELINE M. HUGHES, R.N., has resigned the superintendency of the Bellaire City Hospital, Bellaire, Ohio, to accept a similar position at the Salem General Hospital, Salem, Ore.

DR. W. H. SLAUGHTER has been appointed medical officer in charge of U. S. Marine Hospital No. 6, Cleveland, Ohio, succeeding **DR. L. P. H. BAHRENBURG** who will have charge of alien examinations in Denmark.

DR. HENRY M. HURD, who was superintendent of the Johns Hopkins Hospital, Baltimore, Md., for twenty-two years, recently died at his home in Ventnor, near Atlantic City, N. J., at the age of eighty-four years.

W. S. KOHLHAAS has been appointed superintendent of the Harrisburg Hospital, Harrisburg, Pa., succeeding **FRANK E. BROOKE**, who resigned recently. **MR. KOHLHAAS** has been connected with the Harrisburg Hospital since 1922 and was promoted to the superintendency from the position of comptroller and purchasing agent.

DR. E. E. SYRKIN is the new medical and general superintendent of the Beth Abraham Home for Incurables, New York City.

L. E. JERDONE recently resigned as superintendent of the Pulaski Hospital, Pulaski, Va. The name of her successor is not known.

G. M. MURRAY, R.N., formerly superintendent of the Neepawa General Hospital, Neepawa, Manitoba, is the new superintendent of the Victoria Public Hospital, Fredericton, New Brunswick.

AUSTIN J. SHONEKE has been appointed superintendent of the New Rochelle Hospital, New Rochelle, N. Y. **MR. SHONEKE** was formerly superintendent of the Lutheran Hospital of Manhattan, New York.

REV. JOHN F. BOLAND, in charge of Catholic Hospitals for the Buffalo diocese, has returned from Europe where he visited hospitals in Italy, Switzerland, France, England and Ireland.

RENA ECKMAN is supervising the development of the dietary department of the new Montefiore Hospital, Pittsburgh, Pa. **MARION PETERSON** succeeds **MISS ECKMAN** at Warren Hospital, Warren, Pa.

MRS. GERTRUDE WARD was recently appointed superintendent of the Erie County Tuberculosis Hospital, Erie, Pa.

LILLIAN HOGATE, R.N., is temporary superintendent of the Pekin Public Hospital, Pekin, Ill.

MARY A. DORMER, R.N., superintendent of the Waterloo Memorial Hospital, Waterloo, N. Y., for the past four years, recently resigned. **ALICE INGOLDSBY** has been appointed temporary superintendent.

BEATRICE TREMPER, R.N., formerly assistant superintendent of the Thompson Hospital, Rhinebeck, N. Y., succeeded to the superintendency of the hospital upon the resignation of **PEARL E. PARKER**.

DR. H. W. MITCHELL was reelected superintendent of the Warren State Hospital, Warren, Pa., at the annual meeting of the trustees.

MRS. F. S. CARLILE is the superintendent of the new Belleview Hospital, Tulare, Calif., which was recently opened.

DR. J. W. BRUTON recently resigned the superintendency of State Hospital No. 3, Nevada, Mo., because of ill health. No successor has been appointed as yet.

GERTRUDE A. LAMBERT has resigned her position as superintendent of the Mary A. Alley Hospital, Marblehead, Mass.

HENRY D. BRANDES, treasurer of the hospital corporation, is acting superintendent of the Lutheran Hospital of Manhattan, New York City.

ADELAIDE LEWIS is the new superintendent of the Memorial Hospital, Monongahela, Pa., succeeding **OLIVE MCWILLIAMS**, R.N., recently resigned.

DR. CRAIG BARROW has been appointed superintendent of the new hospital built by the Central of Georgia Railway in Savannah, Ga.

DR. E. L. HOOPER, formerly superintendent of the State Hospital for Feeble-Minded, Orient, Ohio, has recently been appointed superintendent of the Dayton State Hospital, Dayton, Ohio. He will be succeeded at Orient by **DR. C. C. KIRK**.

DR. EUGENE B. ELDER, formerly superintendent of the Georgia Baptist Hospital, Atlanta, has been appointed superintendent of the Morrell Memorial Hospital, Lakeland, Fla., succeeding **MARGARET B. COWLING**, resigned.



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News of the Month

PAMPHLETS ON CLINIC WORK AVAILABLE

The Committee on Dispensary Development of the United Hospital Fund of New York City has recently completed a six-year program financed by the Rockefeller Foundation. This program was devoted to the study of clinic conditions in New York City, the development of standards, and practical experiments to demonstrate what could be done to bring about improvements in practice. The committee has issued the following pamphlets dealing with important phases of its work:

THE CORNELL CLINIC, 1921-1924. Medical Service on a Self-Supporting Basis for Persons of Moderate Means.
By the Committee on Dispensary Development.

WHAT CONSTITUTES ADEQUATE MEDICAL SERVICE? A Study of Methods and Results in Caring for Two Hundred Cases of Chronic Illness in Ambulatory Patients.
By Samuel Bradbury, M. D., with an Introduction by Richard C. Cabot, M. D.

HUMAN FACTORS IN CLINIC MANAGEMENT. A Study Made in the Minor Surgical and Fracture Clinics of the Out-Patient Department of Presbyterian Hospital, New York.
By Mary K. Taylor, with a Foreword by David C. Bull, M. D.

NEW CLINICS FOR OLD. A Study of Clinics Unattached to Hospitals in New York City: The Passing of the Old "Dispensary" and the Rise of Health Centers and of other Clinics Rendering Health Services.
By Michael M. Davis, Ph. D., and Anna Mann Richardson, M. D.

HEALTH SERVICES IN CLINICS. Suggestions as to Content and Method of Clinic Services for the Promotion of Health Based on Work with Various Agencies and Types of Problems.
By Anna Mann Richardson, M. D.

BETTER DOCTORING—LESS DEPENDENCY. Study of the Relations between Medical and Nonmedical Agencies with Special Reference to Clinic and Family Welfare Service.
By Louise Stevens Bryant, Ph. D., with a Foreword by John A. Lapp, LL.D.

A MEDICAL SOCIAL TERMINOLOGY. Preliminary Report of a Study in Classification and Terminology for Case Work in Hospitals and Clinics.
By Gordon Hamilton, with a Foreword by Hugh Auchincloss, M. D.

COMMUNITY DENTAL SERVICE IN NEW YORK CITY. A Survey of Dental Clinics and Other Organized Facilities.
By Michael M. Davis, Ph. D., and Clare Terwilliger, R. N.

GROUP CLINICS. A Study in Organized Medical Practice.
By Walter C. Klotz, M. D.

MEDICAL CARE FOR A MILLION PEOPLE. A Report on Clinics in New York City and of the Six-Years' Work of the Committee on Dispensary Development of the United Hospital Fund, 1920-1926.

During the course of its six years' work many reports and articles were also published or reprinted on such subjects as: relation of clinics to hospitals, to medical practice, and to public health work; nursing service in clinics; unattached clinics and health centers; pay clinics; social service in clinics; follow-up; admission systems; records; statistics; and standards, both general and for particular clinics.

A limited number of these publications, together with the monographs listed above are available on request to the Associated Out-Patient Clinics, 244 Madison Avenue, New York. There is no charge except for postage.

MARQUETTE UNIVERSITY OFFERS TWO WEEKS' ADMINISTRATION COURSE

The college of hospital administration of Marquette University, Milwaukee, Wis., announces a two weeks' course for hospital administrators to be given in November. The course consists of a series of lectures given by the faculty of the college, supplemented with lectures by outstanding specialists in hospital work from various medical and hospital centers.

The course is open to anyone interested in hospital work, and offers an exceptional opportunity to those who cannot spend longer periods of time in obtaining the best and newest ideas of hospital activities.

Classes begin on November 7 and are concluded on November 19. For further information and for registration, write to Dr. John R. Hughes, Dean, College of Hospital Administration, Milwaukee, Wis.

TEMPLE UNIVERSITY COURSE STARTS OCTOBER 6

There will be a special evening course in hospital and institutional management at Temple University, School of Commerce, Philadelphia, under the direction of C. S. Pitcher, superintendent, Presbyterian Hospital, Philadelphia. The first semester will open on the evening of October 6 and continue once a week until February 2. The second semester opens on February 9 and continues once a week until May 24. An excellent course of instruction has been arranged this year with Mr. Pitcher, Mrs. Eden, Miss Pippitt and Mr. Burlingame instructing. The time of classes is from 7:30 to 9:30 p. m. each evening, and it is expected that a larger number of students than ever before will register for the classes.

WHERE TO GO FOR A SUN BATH

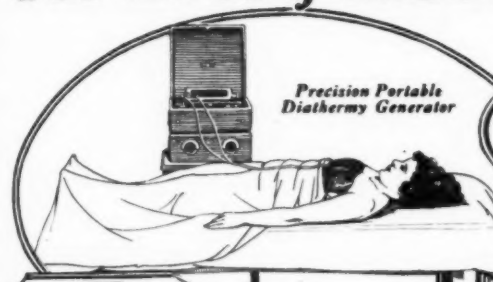
The St. John's Guild Seaside Hospital, New Dorp, S. I., New York, is making a specialty of sun treatment. Children in need of supervised heliotherapy are especially desired as the hospital has excellent facilities for such treatment.

COMING MEETINGS


- American Association of Hospital Social Workers.**
President, Mrs. Charles W. Webb, Lakeside Hospital, Cleveland.
Secretary, Helen Beckley, 18 East Division Street, Chicago.
Next meeting, Minneapolis, Minn., October 11 to 13.
- American College of Surgeons.**
President, Dr. W. W. Chipman, Montreal.
Director General, Dr. Franklin H. Martin, 40 East Erie St., Chicago.
Next meeting, Detroit, Mich., October 3-7.
- American Dietetic Association.**
President, Florence Smith, St. Mary's Hospital, Rochester, Minn.
Secretary, Quindara Oliver, 25 Marlboro Street, Boston.
Next meeting, St. Louis, Oct. 17-19.
- American Hospital Association.**
President, Dr. R. G. Brodrick, University of Stanford Hospitals, San Francisco, Calif.
Executive secretary, Dr. William H. Walsh, 18 East Division Street, Chicago.
Next meeting, Minneapolis, Minn., October 10-14.
- American Occupational Therapy Association.**
President, T. B. Kidner, 175 Fifth Avenue, New York.
Secretary-treasurer, Eleanor Clarke Slagle, 175 Fifth Avenue, New York.
Next meeting, Minneapolis, Minn., Oct. 10-14.
- American Protestant Hospital Association.**
President, Robert Jolly, Baptist Hospital, Houston, Texas.
Secretary-treasurer, Dr. Frank C. English, Christ Hospital, Cincinnati.
Next meeting, Minneapolis, Minn., October 8-10.
- American Public Health Association.**
President, Dr. Charles V. Chapin, Superintendent of Health, Providence, R. I.
Executive Secretary, Homer N. Calver, 370 Seventh Avenue, New York.
Next meeting, Cincinnati, Oct. 17-21.
- Children's Hospital Association of America.**
President, Robert E. Neff, Robert W. Long State Hospital, Indianapolis, Ind.
Secretary-treasurer, Bena M. Henderson, Children's Hospital, Milwaukee.
Next meeting, Minneapolis, Minn., Oct. 12-13.
- Oklahoma Hospital Association.**
President, Dr. L. E. Emanuel, Chickasha.
Secretary-treasurer, Mrs. E. E. H. Moore, Shawnee City Hospital, Shawnee.
Next meeting, Miami, Nov. 8-9.

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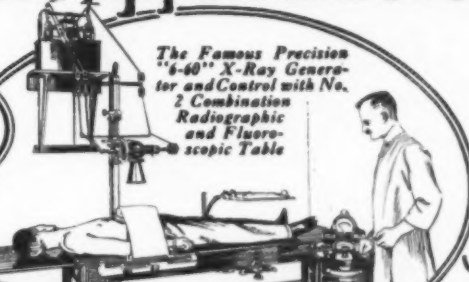
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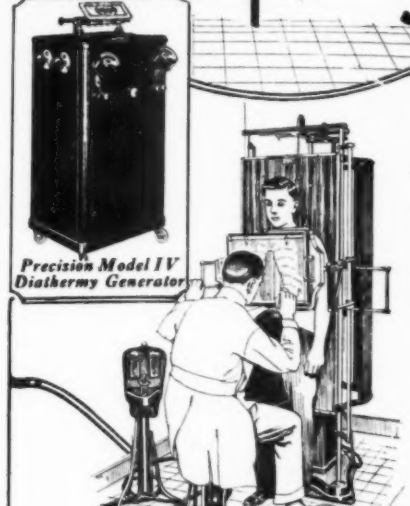
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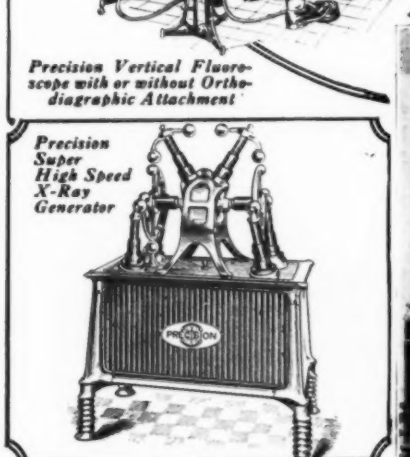
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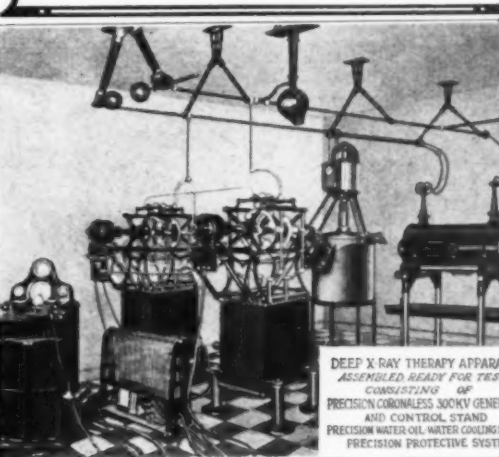
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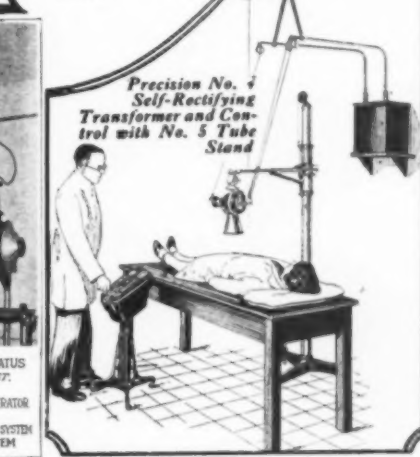
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YOUR EVERYDAY PROBLEMS

A department devoted to the informal discussion of problems arising in the everyday life of the hospital superintendent.

[No attempt has been made to offer final conclusions relative to the questions considered in this department. **THE MODERN HOSPITAL** will gladly welcome further comment by its readers on any of these problems, or the presentation of other queries for discussion in later issues.—Editor.]

Is Fumigation Essential?

The superintendent asking this question, desires also to know when and how fumigation should be performed, provided the first portion of the question is answered in the affirmative.

It is presupposed that this query refers to the attempt at the destruction of the causative organisms of contagious disease. As our knowledge grows in regard to the methods of transmission of contagions, our faith in the flooding of rooms with gases diminishes. The use of sulphur and formaldehyde for this purpose seems to be on the wane. Physicians are coming to be more than ever convinced of the infrequency of airborne transmission of these conditions. The use of gaseous substances in preparing for further use rooms or wards previously occupied by contagious cases, has the advantage of being convincing to persons who are around that something strenuous is being done.

It is doubtful whether there is any necessity for this procedure. Health departments of cities of the first class in the United States have practically abandoned the use of sulphur and formaldehyde for this purpose. One superintendent of a general hospital has repeatedly removed cases of scarlet fever from adult wards, and after disinfecting bed clothing and mattresses by the use of steam, and cleansing the bed with soap and water, has proceeded with the work of the ward as if nothing unusual had occurred, and no secondary case has been seen. To be sure, in rural communities it is rather expected that fumigation will follow the removal of a contagious case.

Whether the lay belief in the efficiency of this act justifies its use, is doubtful. Soap, water and sunshine, with the admixture of considerable muscular effort, appear entirely adequate to render safe an infected ward or room, once the source of this infection has been removed.

May Surgeons Operate Without a Signed Permission?

This question was asked because in a certain institution, a surgeon demanded that he be permitted to proceed with his operation, even though no permission had been obtained from the patient. The patient's operation was not an emergency one. The head nurse in charge of the operating room refused to prepare for the operation, because no signed permission was in evidence.

There is much justification for a rigid enforcement of the rule covering this point. In one instance an ethical surgeon was repeatedly threatened throughout his whole

professional life, by relatives of a patient upon whom he had operated without having a signed permission from an authoritative person.

Hospital superintendents on not a few occasions have been confronted with the statement that an operation was performed upon one of their patients without permission. Fortunate are they who are always able to produce a signed agreement allowing the surgeon to operate. In cases of emergency, the superintendent usually is authorized by his board to permit the operation to go forward, even without a signed permission, the superintendent standing in the place of the parent in so far as the patient is concerned.

In cases where there is no urgency, and where the operation permission has not been procured because of oversight, or negligence on the part of some hospital officer, it would seem perfectly justifiable to require that the permission be signed before the anesthetic is started. This is particularly true in cases of unconsciousness or where the patient is not of age. Usually the permission of a relative can be obtained without great delay.

In the above instance, it seems that the superintendent of the hospital should lay the danger of proceeding without an operation permit before the surgeon, and in case he refuses to delay the operation, the superintendent certainly has the authority to require that the hospital be fully protected under the circumstances.

How Much Should Each Social Service Visit Cost?

In the institution from which this question emanated, there is a social service department consisting of ten workers. The annual budget for salaries in this department is \$15,500. In 1926 these workers handled 6,200 cases and made 4,000 home visits.

There is a feeling among some members of the board of trustees of this institution that this department is costing the hospital too much money, in consideration of the results gained. **THE MODERN HOSPITAL** is asked to comment on this situation.

In eighty-seven hospitals receiving state aid in Pennsylvania, the average cost for each home visit, as gleaned from a recent survey of state-aided hospitals in that commonwealth, ranges from fifty-nine cents per capita in hospitals under fifty beds, to one dollar and eighty-seven cents in teaching hospitals, with an average of ninety-eight cents. This statement, as is suggested in this report, will no doubt be revised in later editions.

Indeed, to compute accurately the cost of each visit of the social worker is no mean problem, because one must consider that she spends much time in performing duties other than home visiting, and that the cost of each visit cannot be learned by merely using the salary budget of the department, for example, as the dividend, and the number of visits made as a divisor.

Whether or not the social worker must travel long or



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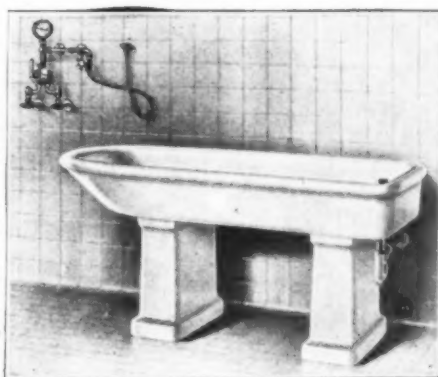
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short distances in making these calls, and whether the hospital furnishes automobile transportation, or requires the worker to make these visits by train or street car, also enters into the problem.

It is sometimes difficult, and it will no doubt be so in this case, for the social service directress to convince her board that the hospital is receiving an adequate income for the money spent in maintaining her department. If the standard of efficiency of hospital social service is to bring a return in money, a dollar for every dollar spent, it must be adjudged a dismal failure. But even by this standard, when it is considered that a visit that costs the hospital \$1.50 may mean the removal of a patient who would require the expenditure of this amount in a fraction of a day, the financial justification of so expensive a visit as this does not remain in doubt.

If it were routinely possible, and it seems neither possible nor feasible, to endeavor to estimate accurately the cost of each worker's out-patient visits, even then the justification of these visits might be difficult to prove. After all, the value of social service work cannot be estimated in dollars and cents, any more than the expediency, from a money standpoint, of the hospital's saving a vagabond's life by the hospital. When boards of trustees come to look upon social service work as a diagnostic or therapeutic contribution essential to the rapid relief of the sick, there will be less discussion as to the economic value of this effort.

Should the Visiting Staff Object to Pay Clinics?

The superintendent who asked this question has had some difficulty in convincing his staff that it is fair to the community's physicians for the hospital to conduct a clinic that requires its attendants to pay cost prices for their treatment.

These physicians contend that if a genito-urinary patient, for instance, were required to pay fifty cents per visit, he could likely pay one dollar to some of the younger members of the staff for an office call.

Laying aside the question as to whether the hospital's out-patient department can more efficiently treat certain types of patients, because of better equipment and more help than can recent graduates of medicine in their private offices, it should be understood that the hospital's pay clinic is not in any way in competition with young practicing physicians.

Each clinic should be provided with the means of preventing persons who are able to pay doctor's office fee from making use of its services. It is not to be denied that in a minority of instances persons will take advantage of free and pay clinics when they should not be allowed to do so. It does not seem wise for these pay clinics to collect more than cost prices for treatment. These prices, of course, may be made to cover the cost of supplies, prescriptions from the hospital's drug store, medication, such as neo-arsphenamin or other specific drugs.

It does not seem to be unjust for the hospital's clinic to charge those who are able to pay a moderate fee. On the other hand, this practice can become an abuse somewhat of the same dimensions as is the promiscuous free treatment of patients.

If the hospital cannot be considered to be in competition with the medical profession when it maintains a cost price of, let us say, three dollars a day for ward service, it would certainly seem that the same principle is applicable to the continuance in the dispensary, at cost price, of treatment inaugurated in the ward.

In the particular instance cited above, THE MODERN HOSPITAL would suggest that the superintendent explain in detail to the members of his staff the aims and methods employed in conducting the institution's pay clinics. This magazine has always believed that a distinct moral injustice is done to individuals who are able to pay, but who are permitted when they become sick to secure from the hospital free service.

An explanation of the hospital's policy to the staff members and to the physicians practicing in the community will usually remove from their minds any tendency to criticize the hospital's pay clinic because they believe it deprives them of monies to which they are justly entitled.

Do Circumstances Ever Justify a General Hospital Treating a Case of Small-Pox

The superintendent who asked this question, adds the following details:

A case of small-pox developed in her hospital. The chief of staff is city health officer. The town has a contagious hospital. The case was placed in a private room, the hospital not quarantined, and approximately eight hundred visitors permitted to enter the hospital on National Hospital Day. The superintendent inquires as to whether she should have permitted this case to remain in the hospital, and visitors to enter its doors, and whether she should have asked the board of trustees to share this responsibility with her.

The local control of small-pox is largely in the hands of the medical profession and the community hospital, augmented by the enlightened moral force of the community's citizens. In a general hospital, not accustomed to carrying out the rigid technique necessary for the handling of diseases so actively contagious as is variola, it would appear neither wise nor expedient to allow such a patient to remain there after the diagnosis had been made. It is the practice in large municipalities with well organized health departments, immediately to remove a case of small-pox to the contagious hospital, as soon as the diagnosis has been made. The hospital in which the disease develops, is quarantined, at least until every person within its doors has been vaccinated, and no visitors allowed to enter until the period of incubation of about twelve days has passed.

The danger of the development of the disease among other patients in an institution in which a case has developed, of course depends on whether the vaccination of patients on admission has been required. The administrator of a hospital which has routinely vaccinated all admissions over a period of months, need have but little fear of the development of a secondary case, even though a full-blown case of small-pox should be discovered within its wards.

To allow a case of variola to remain in a private room in a general hospital, would appear most unwise. To permit visitors, especially children, to enter this hospital, seems indefensible. The superintendent in question would have been wise to have laid this situation before her board, and to have thus caused it to share the responsibility with her. Even though the physician concerned was both the chief of staff and the local health officer, the method of handling this case appears so unusual that it probably would not have received unanimous support had the board of trustees referred the question to the visiting staff. It was not fair to the superintendent to allow her to assume this responsibility alone, even though the physician was chief of staff.

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NURSING AND THE HOSPITAL

Conducted by M. HELENA MC MILLAN, R. N.,
Director, School of Nursing, Presbyterian Hospital, Chicago

OUTLINING A NEW TECHNIQUE FOR NURSING SCHOOL CURRICULA

By Isabel M. Stewart, Teachers College, Columbia University,
New York

NURSES are not the only people who are interested in studying and criticizing curricula these days. Everybody seems to be doing it from the nursery school to the college. The general conclusion seems to be that this rapidly moving modern age has left all our educational institutions a little behind in the procession, or perhaps, more correctly, that the old models of educational machinery are not as well adjusted as they might be to the needs of the modern world. The result is a general overhauling of curricula, in which students, parents and the public are taking a hand, along with teachers, psychologists and educational administrators.

An entirely new technique of curriculum construction has been developed in the last few years, and this in turn has led to the introduction of a whole new group of curriculum experts, so it is with a good deal of hesitation that a layman or even a general educational practitioner now attempts the discussion of such a highly technical subject.

The principles of curriculum construction are, however, simple enough and they apply equally well to general education and to vocational education, to trades or to professions. The only complicating factor in connection with nursing schools is the fact they have two distinct functions and these are apt to get into each other's way. The one function is the education of nurses and the other is the supplying of nursing service to the hospital.

If we could separate the economic or employment functions from the educational one, and could look at them both clearly and handle them independently, the problem would not be so difficult, but we are always getting them mixed up, and this is the main reason why some of us do not always see eye to eye, because one group is likely to be looking at production and the other at educational results. It is useless to pretend that these two functions are entirely compatible. Practically every other type of institution that has tried to run a business on a student service has had the same difficulties and sooner or later has given up the experiment or radically modified it. This modification will come, I am sure, in our own system, in the interests of both the school and the hospital.

In this discussion I am assuming that we all want to

make the nursing school a school and not just a camouflaged working staff for the hospital. This means that the student nurse is regarded primarily as a student and not as a hospital employee. I assume that we all want to do a good educational job, so that the nursing school we are associated with may command the respect and confidence of the community and may win the sincere loyalty and appreciation of its students. I assume that we are all vitally interested in those young students, in their preparation, in their health and happiness and in their professional growth, both now and in the future. Otherwise we have no justification for attempting to operate schools of nursing and invite young women to them for professional training.

In addition, I assume as a matter of course that we are all anxious to secure the best possible nursing care of patients in the hospital. We may differ as to how far students should be depended on for this service, especially when the quantity of service demanded impairs its quality, and when the future usefulness of the nurse in her profession is unduly narrowed and handicapped by the limited range of her service in the hospital. But good nursing methods are as essential to the education of the nurse as they are to the success of the hospital.

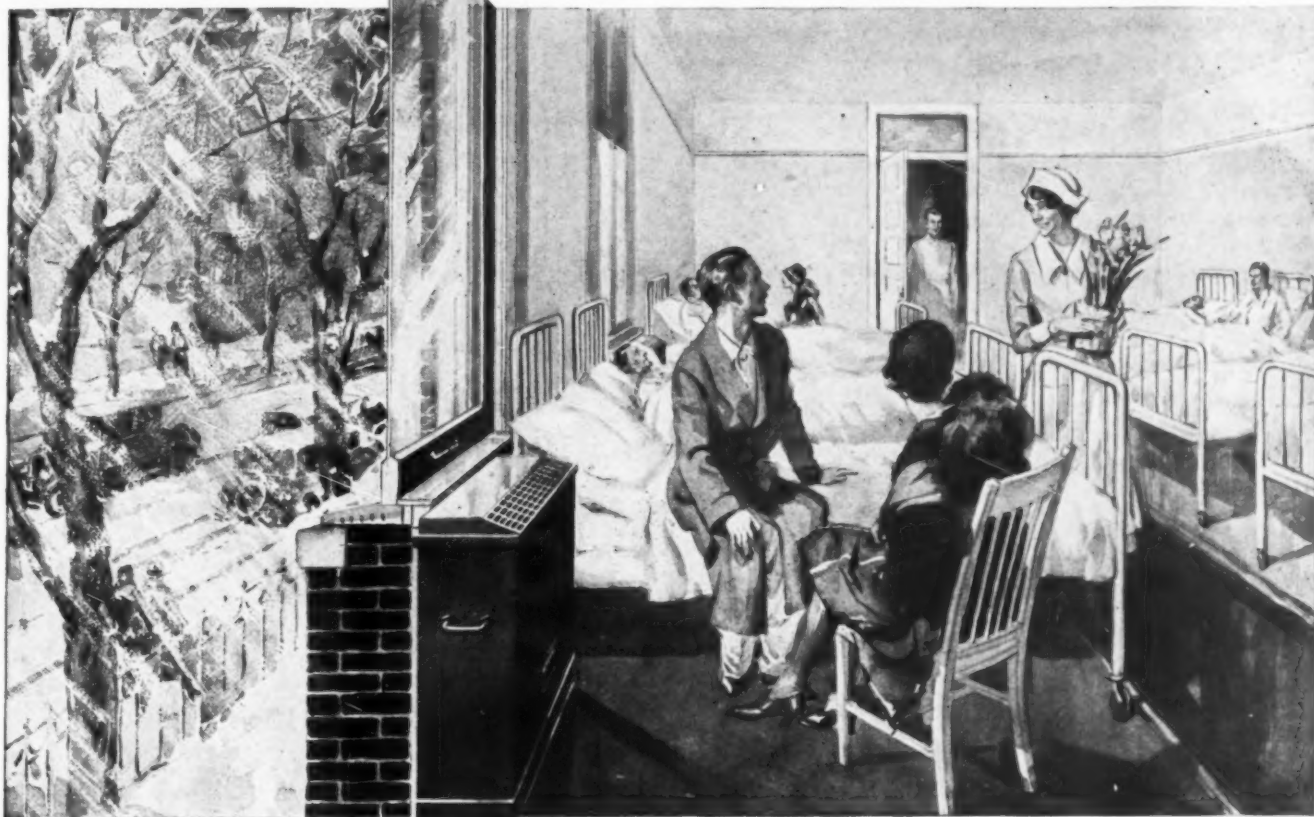
What Is Education?

Assuming then that education must be the primary reason for the existence of a nursing school just as it is of any other school, we next come to the question of what we mean by education. Does it mean the same thing to educate a student nurse as it does to educate other kinds of students? Not long ago at a New York hospital celebration one of the speakers referred with pride to the great contributions the hospital had made "to the education of physicians and the training of nurses." Why the distinction in terms?

As a matter of fact there is a fundamental difference between training and education which I have not time to discuss fully here. The main point is that the methods of training are generally used where people have few adjustments to make, where they are expected to live in a relatively fixed and static order, and to react in much the same way to a limited range of situations. When people are faced with constantly changing situations, requiring

*Paper read at meeting of the Hospital Association of New York State, Syracuse, N. Y., May, 1927.

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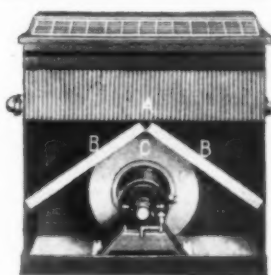


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varied and continuous adjustments, the method of education is the only method that will really work. Nursing schools have tended to use the method of training rather than the method of education, though there are many contradictions in our teaching, as when we insist in the same breath that the nurse must do exactly as she is told and also that she must develop resourcefulness and adaptability and be able to take responsibility.

I have no hesitation in saying that I believe a good many nurses have been over-trained, but I don't think any of them have ever been over-educated. Perhaps one of the reasons why the graduates of our nursing schools have not always adapted themselves easily to their changing patients and to all the varied demands of their profession, is just because of this over-stressing of training at the expense of education. This may be one of the reasons also why nurses do not always continue to grow after they finish their training. The method of training tends to inhibit growth while education stimulates the individual to grow as far as she is able. Indeed, this is the test of true education, that the individual continues to grow freely and naturally not only during the days of schooling but throughout life.

Whether we side with the trainers or the educators, with the "repressionists" or with the "expressionists," we shall need a curriculum, and the curriculum will of course reflect our philosophy of education, which is more or less our philosophy of life.

The curriculum is simply the chart that outlines the path to be traveled. The word itself is an interesting survival of Greek culture, strangely appropriate to our rather hectic pursuit of education in the busy round of hospital life. It means literally "a race-course." In nursing schools we sometimes assume that the theory or class work belongs to the curriculum, the rest being just practical work. But the curriculum of any school includes experiences and activities of all sorts, everything essential to the preparation of the student for her vocation or for life.

Education Has Two Main Objectives

In building a curriculum for a nursing school, we must be quite clear not only about the kind of education we want to give but about the major objectives we want to reach. Here again we have to ask ourselves whether we are to accept the two main reciprocal aims which hold for all other branches of education or whether nurses belong in a class by themselves. These aims are, first, to prepare people to meet social needs and to adjust themselves to community life and its demands, and second, to help these individuals so that they can develop whatever potentialities may be in them and may live rich, happy and satisfying lives.

There has never been any question in nursing schools about the first aim, except that we have sometimes had rather a narrow and out-of-date conception of what the community requires of nurses and what different kinds of social situations the nurse should be prepared to meet. But we do assume that the nurse is being prepared for community service and we want her to give efficient service, though we do not always supply all the elements that contribute to efficiency.

The second aim has not been so clearly seen. There is no real incompatibility between the first and the second aims, though there may appear to be. We have too often assumed that the special kind of service required of the nurse demands a surrender of personal satisfactions and of the ordinary opportunities for wholesome and happy living which are accepted as legitimate and proper in

other vocations. The idea has been that nursing service necessarily means self-sacrifice, and that self-sacrifice means repression, self-effacement, and the giving up of many of the normal satisfactions of life.

This ancient ascetic doctrine is coming into sharper and sharper conflict with the modern spirit and is contradicted by all the teachings of modern psychology and modern ethics. Nursing itself is rich in satisfactions and interests, and offers wholesome outlets for practically all the fundamental, emotional, physical and intellectual drives of normal, well endowed young women.

We have used the physical resources of these young women sometimes to the point of exhaustion, but we have never fully utilized their intellectual capacities or their social interests. Indeed, both in their training and in their professional work, the pathways have been too often blocked, more or less arbitrarily, and the nurse has been hedged in by restrictions which other students and workers rarely have to face.

Character Development Is Checked

Where one's normal intellectual and social equipment is not in full play, the result is a twisting and thwarting of personality and character which does not make for growth or for the most effective service. Under the conditions it is astounding that nurses have been able to accomplish all that they have, and that they are as free as they are from serious personality defects. The vigorous ones have simply overridden the restrictions and have thrown all their mind and heart, as well as their physical strength, into their work.

We must fit the occupation and the system of education to the facts of human nature, as well as to the needs of the community as we see them, otherwise we run the risk of sacrificing not only the physical health but the mental and moral health of one group in order to minister to the health and welfare of other groups. We must remember also that the nurse is a citizen as well as a professional woman, and that she will probably be a wife and a mother. These things cannot be ignored in the training of any group of women.

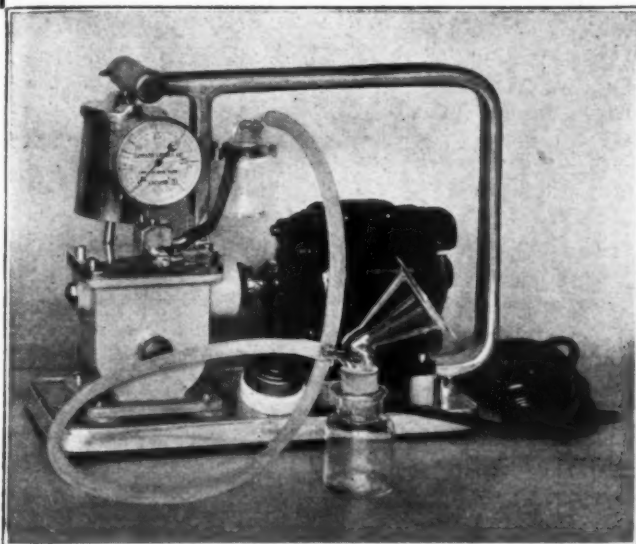
If nursing education could be broadened and liberalized it might serve as a model type of education for young women, whether they ever use it professionally or not. In range of ability, in human interest and in scientific and cultural content it has a richer and more varied offering than most vocations, but we have never capitalized these tremendous educational assets at their full value.

In addition to these general aims or objectives, there are a great many specific objectives that have to be decided upon before a curriculum can be built or evaluated. Nursing schools exist to educate nurses, but what kind of nurses, and what do these nurses have to do in the hospital and when they leave the school? This is where we find the greatest difference of opinion. We do not seem to be able to agree even on what a nurse is. Some people see in her only a manual worker who carries out the plans and ideas of others; some see a professional worker with many and varied responsibilities, who cooperates not only with the physician but with the public health officer, the social worker, the administrator and many other specialists in widely different fields.

The only way of coming to any reasonable conclusion on the matter is to find out exactly what nurses are doing now, in all the representative fields of nursing, and then find which of these duties are common to the body as a whole or to any considerable number of nurses in practice. This can be done by the technique of job analysis which is being used extensively as a basis for curriculum building

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and reconstruction in many fields of education. A beginning has already been made on such a functional analysis and it is hoped that we may have the assistance of physicians and hospital administrators, also of patients, in getting a correct picture of the duties and responsibilities of nurses today.

In addition to this we need to study the qualifications or traits essential to success in nursing. Most of the published specifications for the ideal nurse seem to be prepared by optimistic and idealistic people who expect a combination of virtues and ability rarely found in human beings, and often conspicuously absent in those who make the lists. We shall never be able to produce such paragons, but we need to know where the main excellencies and shortages are in our practicing group, in order that we may help to eliminate the undesirable and cultivate the desirable traits, through our system of selection and methods of education. When a thoroughly scientific study is made in this way we may find that there is a place for schools of different kinds on different levels. Undoubtedly we shall be better able to say what should go into the basic course, what should be left out altogether, and what should be held over for postgraduate courses.

What Is a Basic Course?

There has been much discussion recently on the basic course and on the fundamentals of nursing education. I find that a good many people are confusing these terms with the minimum standard, which is set up by a number of states as a requirement for registration. The terms seem to me clear. A basis is a groundwork; fundamentals mean foundations, and a foundation suggests something solid and substantial, not a few tent pegs to hold a flimsy, temporary shelter. It must be strong enough and broad enough to support the structure which is to be built on it, a structure that will stand up stoutly during the nurse's whole professional life, not one that is built for a brief emergency.

I think of the basic preparation of the nurse as a one-story building which is large and spacious enough to accommodate the general workers in all fields of nursing. Leaders and specialists, organizers and administrators, teachers and supervisors must have further preparation, but it should be possible for such nurses to add a second and perhaps a third story to that original structure without going back to put in new foundations. At present, many of our able and ambitious women in nursing find themselves unable to go ahead because their basic training has been so flimsy and superficial, so badly planned and badly put together, that they would be obliged to build almost from the ground up if they wanted to prepare themselves for second-story positions, or even carry on effectively in ordinary positions.

One of the great controversies at present is over the question of whether any preventive or social elements are to be included in the basic nursing course. To some of our friends this seems like building on a new wing or sun porch to the main body of the house, something in the nature of a luxury which might be nice but which cannot be afforded by practical people. The argument is that the basis of all nursing is sick nursing or what is often called bedside nursing, and that everything in the nature of health nursing is a specialty to be taken up after the basic training has been completed and the nurse graduated. This shows a misconception of the meaning of nursing, which is fundamentally health conservation. To prepare a real nurse, therefore, prevention and cure should both be built into the structure from the foundation up.

Some people seem to have the idea that nursing is restricted to the physical care of the patient and that it consists mainly in things the nurse does with her hands. They expect her to look after the physical environment of the patient, but they insist that the mental and social environment is not her affair. We cannot divide up human beings in this way. Patients are mentally sick as well as physically sick, and they are affected for better or for worse quite as much by psychological and social as by physical conditions. We must be prepared to care for the whole patient and this means that we must emphasize the human and social aspects of all forms of nursing as well as the physical and technical aspects.

So long as 20 per cent and more of our students in ordinary nursing schools are going directly into some form of public health work without additional training, we cannot shift responsibility for their fundamental preparation, and we must either accept it frankly or tell those young students when they apply that we cannot give them what they are looking for. I believe that we have long passed the stage when we can regard public health nursing as a specialty. It is as fundamental as private nursing or general hospital duty, and moreover the elements that go into the basic preparation of the public health nurse are as important for the private duty and hospital nurse. The executives and teachers and supervisors in public health nursing should be on the next level of responsibility and of training, but the regular staff workers must get most of their preparation in the training school and learn the minor details on the job.

Having decided what the average nurse does and what responsibilities she must carry, we must plan a course of education which will teach her how to do these things. Some of the simple duties may require little knowledge or skill and no formal instruction, but most of these duties involve life and death and they cannot be too carefully taught. Nothing should go into the curriculum either of theory or practice that does not contribute definitely to these essential activities and to the development of the qualities required in the nurse and in the good citizen. Nothing should be left out that 75 per cent or even 50 per cent of practicing nurses need in their everyday work.

Arrange Program Systematically

It would take too long to outline all the varieties of knowledge and skill that would emerge from such an analysis. We must synthesize these into teaching units that can be easily handled, and then we must see that the right kind of experience is provided and the whole program arranged systematically so that the essential ground is covered by each student in the best teaching order and at a rate that is neither too slow nor too fast for the ordinary student.

Until we have made such a careful study as I have outlined I do not think anyone can say what proportion of the time in a nursing school curriculum should be spent in practice and what proportion in learning about practice. We can say, however, that our present ratio of theory is extremely low. If we compare the theory and practice in our nursing schools with that which holds in any other familiar type of professional school, we shall find that three or four hours of theory to one hour of practice is common, half and half is considered about right in schools for dietitians and social workers and teachers, but when we come to nursing schools, one hour of theory to eight or ten of practice is regarded as exorbitant and positively dangerous, while one in fifteen or twenty is the "reducing" diet on which most schools subsist.

(Continued on page 176)

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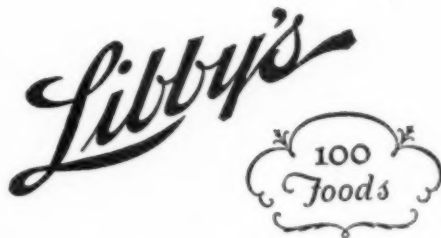
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1 cup granulated sugar 1 teaspoon chopped mint
2 tablespoons gelatine (dissolved in 2 table-
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Cook pineapple (with its syrup) and sugar until boiling. Add gelatine, dissolved. Set aside to cool. Before congealing, fold in cream whipped very stiff, adding chopped mint last.

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AVOID STRUCTURAL ERRORS AND INCREASE DIETARY EFFICIENCY

By Lulu G. Graves,
New York

IN PLANNING the architectural division of a dietary department one must be guided by the needs of the individual institution. Some of the principal features are necessary to all hospitals; others are necessary to some hospitals but not to all. When these are determined due consideration may be given to the location, arrangement of the rooms and the amount of space required.

Provision must be made in all hospitals, large or small, rural or urban, for a main kitchen; storerooms for vegetables, canned goods and groceries, reserve supplies and

utensils; dishwashing room; preparation room; refrigerators; dining rooms for doctors, nurses, employees; dietitian's office; diet kitchens or serving pantries; space for parking delivery trucks.

In many hospitals additional provision is necessary for a bakery with bread and pastry room; teaching laboratory; metabolism kitchen; laboratory for infant feeding formulas; lecture room; dining room for graduate nurses and hospital staff.

Efficient food service depends in no small measure upon the original planning of these rooms and their equipment.



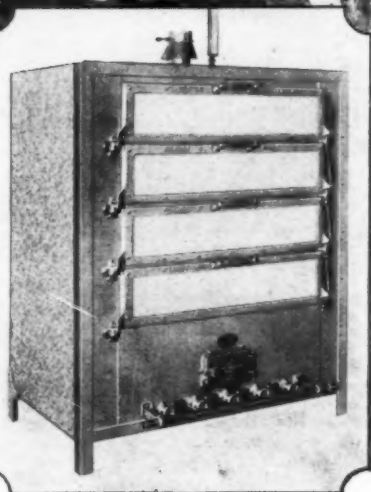
Main diet
kitchen,
Cooper
Hospital,
Camden,
N. J.



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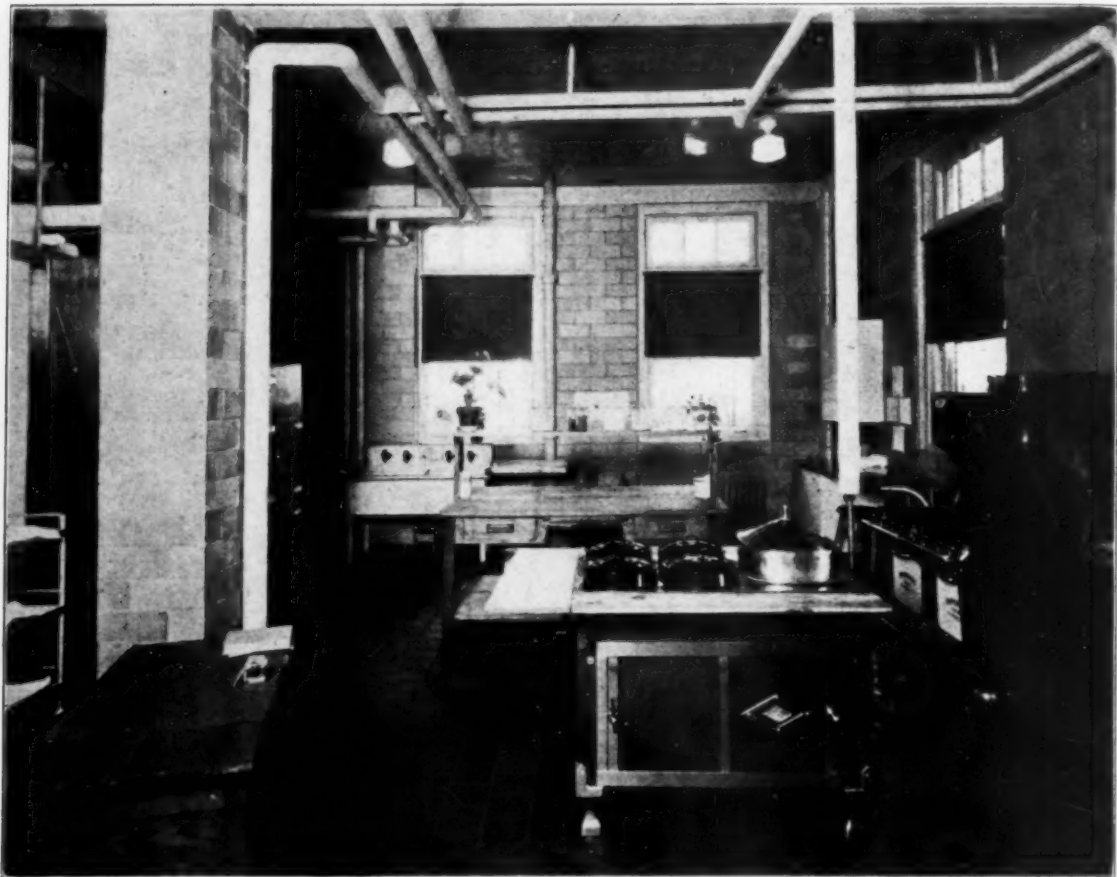
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Grouping the divisions in the first of the above lists, including the dining rooms, on one floor promotes ease and rapidity of work. This is particularly true in the smaller hospital, where vertical deliveries are feasible.

Interdepartmental cooperation has been more successfully accomplished in small hospitals, where a more intimate contact with the patient is also possible. Concentrating the work in one place not only facilitates the serving of meals but stimulates these other interests.

The divisions in the second list represent a more specialized work and need not be included in the group, although the fewer the bases of supplies, the greater the economy.

First Floor Is Good Location

For the small and medium sized hospital, the first floor will generally be found to be the best location for the dietary department. For the large hospital, a separate service building is desirable, if possible. The first floor is accessible for delivery of supplies from the outside, and also for various contacts with other departments inside. With the progress in systematic business administration in hospitals, and the now common practice of dietotherapy, these contacts between the dietary department and other departments of the organization are becoming important.

The first floor provides for economy of administration; good lighting and ventilation; convenient arrangement of dining rooms which may be made pleasant and comfortable; and, last but not least, good service.

The top floor has the advantage of being well lighted and cool, if properly built. The kitchens are pleasant to work in, and the dining rooms are attractive, quiet and restful. This plan is not generally adopted because of the additional cost of construction and increased cost of operation. When finances permit, the psychological effect, the atmosphere of cheer created during the meal hour,

and its effect on the personnel as they return to duty, justifies the expenditure.

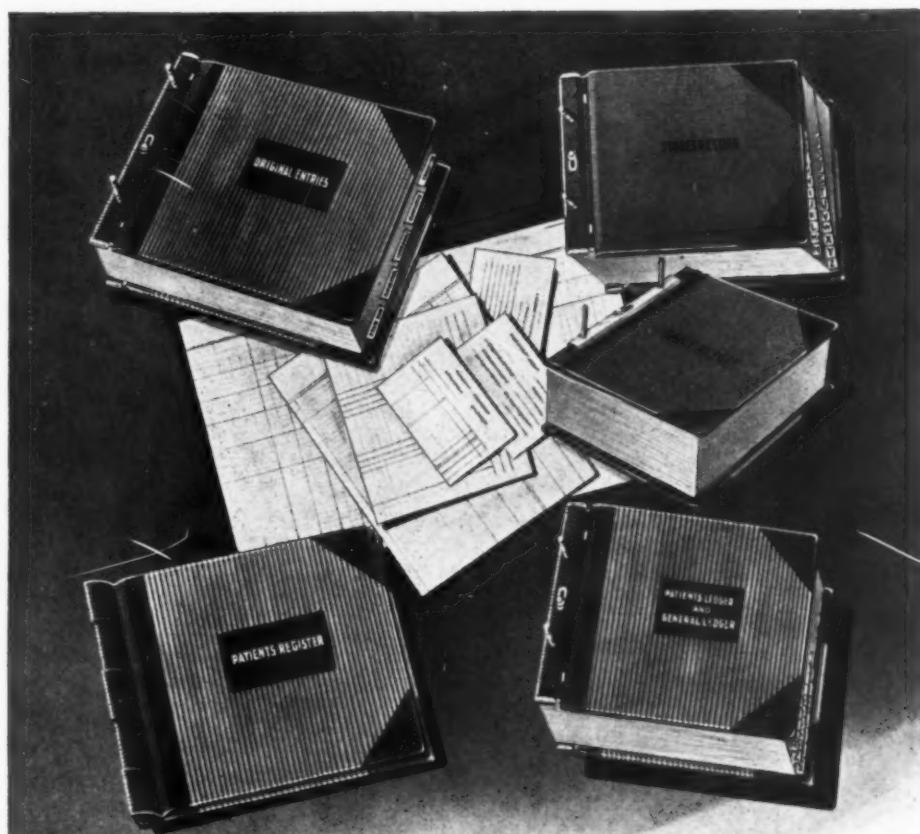
A basement having artificial light and ventilation is not the place for a dietary department. If in the building program it seems necessary to put this department below the street level, there should be sufficient excavation to permit of some natural light.

Dark, underground kitchens are apt to have many pipes and other construction devices that take up much space and in most instances are difficult to keep clean and sanitary, besides being cumbersome and unsightly. Kitchen employees are human and in common with all human beings they are apt to have the same attitude toward their work as is shown by the authorities in the organization. If the workshop indicates negligence or indifference, the workers will show these same traits.

Probably no other department affects hospital architecture more than the dietary department. Designing kitchens is not a simple task that may be performed by anyone, as it was once considered to be. No kitchen plan and equipment should be completed without the judgment of someone familiar with the details of work to be done in it. It is pretty general practice to leave the planning of the kitchen largely to the architect, and the planning of the equipment to a representative of an equipment house. Both of these authorities are essential, and their judgment is good so far as their experience goes, but neither of them is familiar with the numerous details that are necessary in the day's work and that play no small part in making or marring efficient service.

For example, the arrangements in one dietary department recently visited necessitated many of the dishes being carried across the entire length of kitchen and hall, four times during every meal. When the dishes were brought from the floors, they were transported across this space to be washed; when washed, they were carried back

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Simple—Efficient—Complete—Economical

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to a room near the elevator to be stored until the next meal; later, the salad plates, dessert dishes, and all dishes for special orders were taken the entire distance to the preparation room, and returned to be placed on the trays. There was no reason why all these rooms could not just as well have been placed on the same side of the kitchen, and the rooms adjacent to the tray service room been located on the opposite side. The time and labor lost in this useless travel is appalling, and this great loss will continue for many years. Yet this was a good looking kitchen, well equipped and, to the casual observer, modern and fine.

On a visit to the dietary department of a large public hospital completed about a year ago, approximately \$6,000 worth of equipment was noted which had never been used and never will be used, but it will stand in its place to be kept clean and to be cleaned around, indefinitely. These are but two illustrations of situations that are common.

On the other hand, it is gratifying to find a number of departments that are adequate and that serve their purpose well. Cooper Hospital, Camden, N. J., is one of these. Helen Markley, chief dietitian at that hospital, says both kitchens, shown in the illustrations, are "working out very well, and there is nothing I would care to change, or have different except larger wheels on the tray trucks." When no greater mistake than that can be found, after nearly a year's use, it comes near to being a satisfactory kitchen.

The dietary department in the Toledo Hospital, Toledo, Ohio, is another in which the arrangement of rooms and grouping of equipment are such that no unnecessary steps are taken and no time is consumed in fruitless effort. It is gratifying to be able to state that in both of these hospitals the dietitian was called into council. Again, we might say these are but two illustrations, but there are many departments that are well planned and are functioning well under the management of a competent head.

Not all dietitians are prepared to pass on plans, but if the local dietitian is not qualified to do so, there are others to whom appeal may be made. A competent chef will be able to give helpful suggestions, and we are looking forward to the time when every hospital will have a competent chef.

It might be well to mention some of the points that are of importance in the day's work, but are not evident to the one who is building or remodeling a dietary department for the first time, or for other reasons is not familiar with the details of kitchen construction.

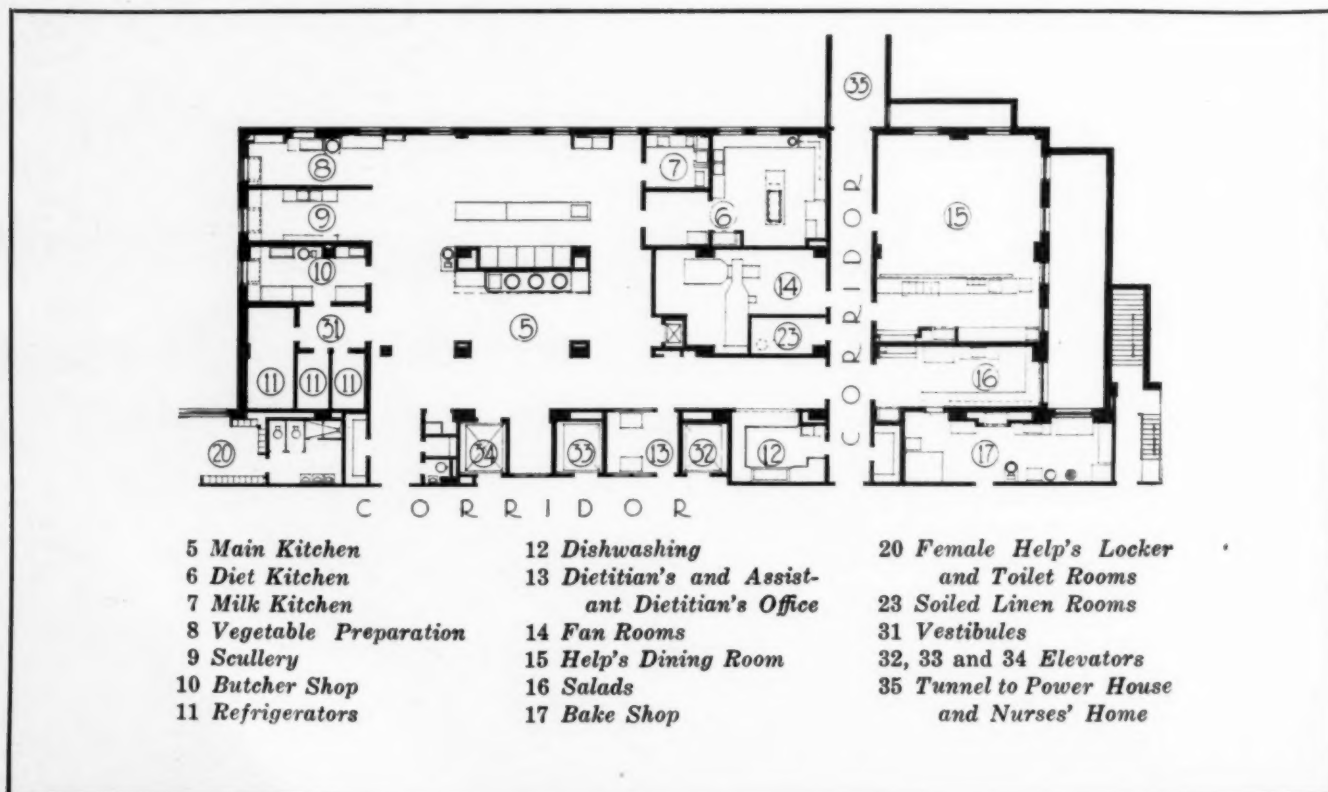
The receiving room or storeroom should not be so placed that the deliveries interfere with the work of the kitchen employees. Most deliveries are made in the morning, at the busiest time in the kitchen. The receiving room or storeroom should, however, be convenient to the entrance of the kitchen or to stairs and elevators leading to it. These rooms should be well ventilated and cool. Concrete or tile floors and metal shelves and bins are preferable to wooden construction.

Dishwashing and vegetable preparation should be done in rooms separate from the main kitchen. If partitioning off entire rooms for this purpose is not feasible, a partition extending part way up from the floor will answer. This may also be an aid to lighting and ventilation.

Dishwashing and vegetable preparation should not be done in the same section, but a partial partition is sufficient here also. With two processes going on there will be more confusion and friction, resulting in increased breakage of dishes and an additional outgo of fruits and vegetables. Temptation is strong when appetizing foods are at hand and the fewest possible number of persons should be subjected to this temptation.

Broilers, stockpots, vegetable cookers and work tables should be grouped around the range. A sink with high faucets at one end of the cook's table saves him many steps, and assures washing of everything that should be

(Continued on page 182)



Section of ground floor plan, Toledo Hospital, Toledo, Ohio



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OUT-PATIENT SERVICE

Conducted by MICHAEL M. DAVIS, Ph.D., Executive Secretary, Committee on Dispensary Development, United Hospital Fund of New York, 151 Fifth Avenue, New York
A. K. HAYWOOD, M.D., Superintendent, Montreal General Hospital, Montreal, Que.

FEATURES THAT DISTINGUISH GROUP CLINICS FROM THE OUT-PATIENT SERVICE OF HOSPITALS*

By Walter C. Klotz, M. D., Director of the Clinic, Cornell University Medical College, New York

FROM the aspect of medical service, group clinic patients represent the usual ambulant types encountered in the out-patient departments of endowed hospitals, in teaching clinics and in the usual free clinic.

The cases met with in these classes of institutions constitute the usual range of milder or at least less acute conditions that comprise the bulk of general medical practice. In the group clinic material there is perhaps a larger proportion of more obscure chronic conditions that require intensive clinical study in order to determine a diagnosis.

For the student of clinic service and development it might be of interest to have a description of methods and procedures employed by private group clinics in providing medical service for a class of patients that represents a composite economic group, the same composite economic group seeking medical care in the offices of individual private practitioners in the same communities. In what respects might the methods of private group clinics be employed to improve the medical service of endowed out-patient departments or free clinics? What features of endowed clinics on the other hand might lend themselves to the betterment of group clinics?

As a rule the interiors of the clinics visited for the purpose of this study were attractive, comfortably furnished and in good taste. There was no instance of lavish display. One found an occasional bowl of goldfish or a potted fern to give a homelike touch. In the newer buildings, the central waiting room, with peripheral corridor connecting the various offices, duplicated the arrangement of the Mayo Clinic, Rochester, Minn. This plan has been elaborated, especially in the Cleveland Clinic, Cleveland. In the case of office buildings this has not been feasible, the waiting room being placed at the entrance and the examining offices on either side of an axial corridor extending the length of the suite. In one especially arranged building departmental waiting rooms had been provided to insure more prompt routing of patients to a point as near the assigned examining office as possible.

Definite figures in regard to income and costs were

*This article is based upon personal visits and a study made in November, 1926, of fifteen group clinics, in the Middle Western states. The study was made at the request of and under the auspices of the Committee on Dispensary Development of the United Hospital Fund of New York. The complete report, of which this article is an abstract, may be obtained on request from the Associated Out-Patient Clinics Committee, 244 Madison Avenue, New York.

difficult to obtain. What little information is available was reached by induction. The fees were usually those of private practitioners for the same economic groups in the given community. All of them had a sliding scale of charges according to financial rating. Most of the work was done on a credit basis. Discounting, or adjusting of charges, was the regular practice, as in the case of individual physicians, according to the services rendered and the ability of the patient to pay. The usual statement made by members of the group was that their net income was probably not so high as it would be if they were working alone, but that they were able to give their patients better medical service owing to the better diagnostic facilities made available through the group organization. Little information could be obtained as to the cost of the general overhead. This seemed to be a troublesome question. It had evidently been discussed in some cases at a recent conference. One of the difficulties had been to determine just what actually constituted overhead and what items ought to be included.

In view of the general credit basis, rather complete accounting procedures, with individual ledger accounts for each patient, were necessary. It was explained that, while business methods and a system of prompt statements were desirable, it was necessary to extend credit rather liberally, especially in connection with the agricultural population, according to crop seasons.

Routing of Patients Simple

The methods of routing and registering patients were usually found to have been made as simple as possible. As there were no economic or social restrictions to be imposed, it was not necessary to make inquiries in regard to income and resources, except to obtain such necessary information as would be sought by the credit department of any department store handling charge accounts. Age, address, occupation of head of family or person responsible would, of course, be essential items. The patient would be given one copy of the registration slip or card, a duplicate being retained for the accounting office and record office. In larger clinics this would be in triplicate, to include one copy for the record office to complete the index of clinical histories.

As no fees were collected in advance, there was no discussion of charges, and the patient would be either di-

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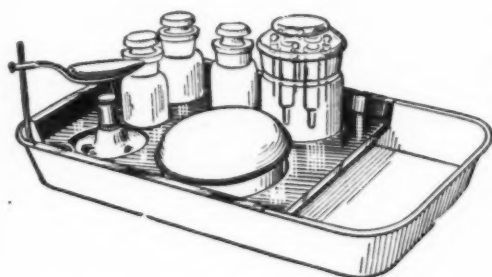


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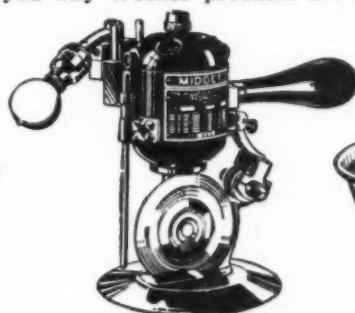
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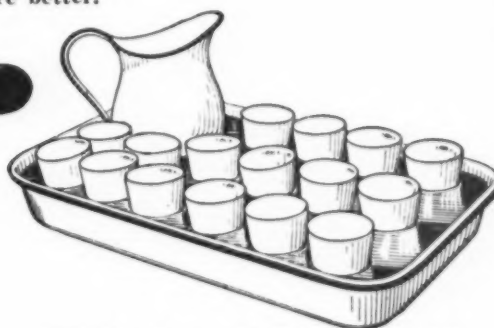
WM852. Clark Hypodermic Outfit. Consists of a white enameled tray with separate, removable, nickel plated inner frame into which fit the following articles; 1 Hypo Jar for syringes and needles, 1 white enameled needle box, 1 alcohol lamp with spoon, and three glass stoppered salt mouth bottles. Size of tray 14 inches by 8 inches.

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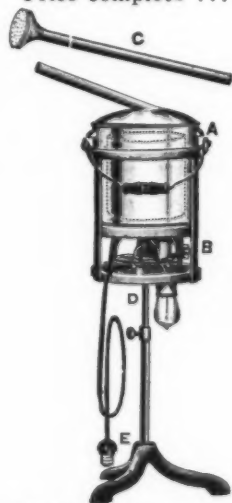
Cut 100 layers of gauze in one operation. No effort, no exertion, easy and safe to operate, made in two sizes.

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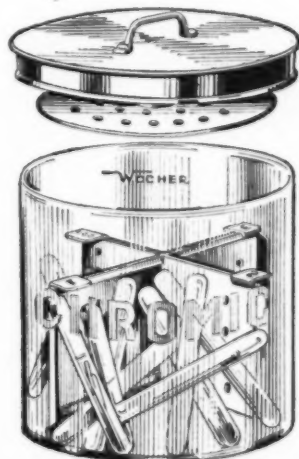
WM858. Logan Medicine Tray, white enameled, nickel plated inner frame. The latter has apertures to hold sixteen medicine glasses or white enameled cups and a 1 quart pitcher. Compact and easily carried. Size of tray 16 inches by 10 inches.

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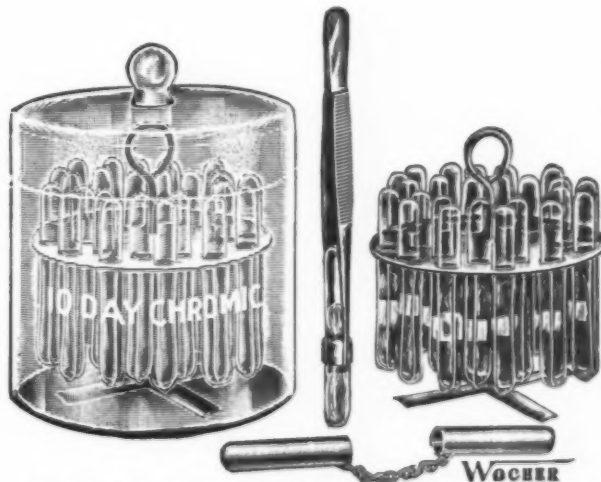
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WM820. Kraemer Catgut Jar. Keeps tubes in sterile solution. Marked Plain, Chromic, etc.

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WM816. Marting Catgut Outfit. Keeps tubes immersed. Jars are indelibly marked, Plain, Chromic, etc. Complete with removing forceps, tube breaker, etc. Price.....\$15.00

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rected or ushered to the point nearest the examining room to which the case had been assigned for first examination. This matter of assignment is important from the point of view of medical service and will be discussed more fully below.

In connection with registration, it is of special interest to understand the manner and atmosphere rather than the technique of the procedure, as compared with the average charitable clinic of the old type. The patient is, after all, a client and a customer. He is treated as such. The clinic takes the stand that the patient comes to buy a certain commodity, for which, presumably, he is willing to pay a certain commensurate price. The clinic can supply this commodity and is willing to do so at a fair and reasonable basis of exchange. Without stressing the commercial aspect of the transaction, the patient is not treated either as socially unfortunate or as a serial case number. As a rule the hours for admission and registration are not limited to certain hours of the day, but continue during the usual working hours customary in the community.

Emergency Service on Sundays

In the case of clinics in smaller cities, drawing their patients from surrounding agricultural sections, Saturday afternoons and evenings are provided for, while certain emergency service is maintained on Sundays. The hours are usually quite long as compared with hospital outpatient departments or endowed teaching clinics. The clinic examining office takes the place of the physician's private consulting office and he does not maintain any other office outside.

As a rule, appointments are not made for first visits, but patients are accepted at the time of application, with the necessity of waiting if the physician happens to be out at the time. These details vary considerably according to the size and character of the clinic.

It was not customary to limit the number of patients seen in any day. They were admitted and registered as long as the clinic was open. If the load was heavy they might be advised to come the next day, unless they wanted to wait. But it was the usual practice to accept and see all patients who presented themselves. Ordinarily examinations and laboratory tests could be completed the same day if only usual routine procedures were necessary. The staff would remain until every patient had been seen and disposed of. It was stated that the usual clinic hours were frequently extended, and that the staff, both medical and nonmedical, remained overtime quite frequently.

Obviously, the quality of medical work done by a clinic group will depend upon the ideals, qualifications, and ability of its medical staff. This it would be difficult to judge fairly without a longer time for observation and study of progress records in given cases, and some opportunity to come in contact with the inner soul of such a group through intimate contact or by actually working and living with them. In a hurried survey such as this has naturally been, a general estimate of the spirit, intelligence, and general attitude must remain the criterion upon which to formulate any efficiency rating. The general reputation in the community, especially among other medical agencies, might be accepted as material testimony. On this basis, the groups visited were apparently conducted by men of good medical education and sincere purpose. There was a spirit of wanting to do good medical work, of wanting to keep up with the progress of medical knowledge and a desire to do the fair thing toward the medical profession outside of the group.

None of the groups concerned limited their work ex-

clusively to diagnosis. Consultation work predominated more in some than in others. A number stated that they were glad to do diagnostic work for other practitioners, and that when they knew a patient had been under treatment by some outside practitioner, they would make every effort to send the patient back to his former physician and supply the physician with a report of the examination. In the case of smaller cities there was usually less consultation service, and in the case of the newer or more recently established clinics it was stated that there was less confidence on the part of the outside profession and some individual antagonism.

In a few of the groups, not so closely organized, patients are assigned to the physicians they ask for, or to whom they are referred. These physicians continue to treat such patients as if they were in individual practice, and consult other members of the group in the same manner and by the same procedure as in individual practice. Other groups, however, insist upon the patient's being assigned to the member of the group best qualified to handle the case in question, making use of other members of the group to complete the study of the case and establish a complete diagnosis.

As was indicated above, none of the groups limit themselves exclusively to diagnostic work, but institute and continue the treatment of the patient, including hospitalization in the affiliated hospital if necessary, unless he is referred back to his former attending physician. None of the groups included in the study limited their practice to any specialty. Surgery seems to predominate, and most of the groups were begun as special surgical groups, but in their development have added internal medicine and the medical specialties, especially urology and nose and throat work.

None of the group clinics publish annual reports, and it seems doubtful whether any complete statistics were compiled by section or department even for their own information. Some could give statements as to the approximate number of patients treated in a year, or the average number of visits per month or year. The need for better medical statistics had evidently been discussed by several groups, and in intergroup conference, with the intention of adopting more exact methods of keeping records of daily visits.

Central Filing in Vogue

All of the clinics visited employed a central filing system and only one set of records for each patient, regardless of the number of departments, sections, or individual clinic members that had been visited or consulted. Each patient had a case number and the records were filed serially according to numbers. As a rule, clinical records were returned to the central record office for filing at the end of the day's work. At the Mayo Clinic they are filed in the different section filing cases until the case study has been completed and the patient disposed of.

The systems of records were remarkably good. It would be tedious to describe in detail the various forms used and the different modifications of appointment, referral and consultation slips. Slips used to indicate basic charges for services, financial ratings, and other functions are adapted to local needs and usage. Various devices were employed to indicate by some mark or tag records of patients who had not paid their charges for former services. Such a mark would set a stop signal all along the line and prevent any further charges being incurred or extension of credit until the business office had been consulted. With few exceptions, all clinics main-

(Continued on page 186)

ACIDOPHILUS THERAPY

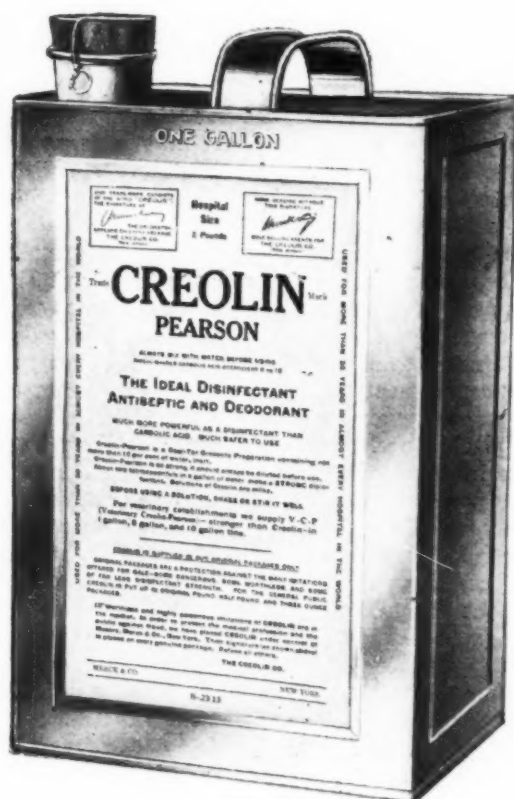
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HOSPITAL EQUIPMENT AND OPERATION

With Special Reference to Laundry, Kitchen and Housekeeping Problems

Conducted by C. W. MUNGER, M.D., Director,
Grasslands Hospital, Valhalla, N. Y.

LABOR-SAVING EQUIPMENT THAT WILL CUT COSTS IN THE DIETARY DEPARTMENT

VIEWED in the light of their services, labor-saving mechanical devices are an important factor in the modern hospital dietary department. Economy, ease of operation, time saving and uniformity of work are some of the factors in favor of dependable machines. The capacity of the hospital and its field of service determine the amount of the mechanical equipment to be provided for the preparation and service of food.

Mechanical kitchen devices play an important part in the daily functioning of the modern dietary department. As practically all such devices are made in two or more sizes, designed to meet the moderate needs of the small hospital as well as the heavier demands of the larger institutions, it is usually possible to obtain a machine of the proper size to meet individual requirements. In the smaller institutions, the more highly specialized machine may not be practical, although certain devices of general application are indispensable if they will reduce salary expense. It is essential that the operation of these machines be placed in the hands of employees who have been taught to understand them and who will operate them economically. Care should be exercised in their operation to reduce the necessity for repairs. Cheap machinery is a poor investment because of inevitable breakdowns.

For the hospital bakery, several types of machines are available that will reduce the amount of hand labor, thus cutting down expense. There are power cake and dough mixers which may also be used for whipping cream, beating eggs, mixing pie fillings, creaming icings, and similar duties. These machines are equipped with attachments for all sorts of kitchen mixing, cutting and beating, and the possibilities of these utility mixers are discussed in detail in presenting the equipment of the main kitchen.

In large institutions it is usually necessary to have the bakery in a separate room with separate mixing machines. Flour handling outfits consist of large bins, into which the flour is emptied and blended. It is then sifted and delivered to the storage bins in a fluffy, well aerated condition, ready for use when needed for mixing a batch. Loaf molding machines are time- and labor-savers. The machines have the same action as hand molding, but mold the loaves more rapidly and uniformly.

Another type of bake shop equipment is the self-contained unit which sifts, mixes and weighs the flour, tempers and weighs the water, mixes bread and rolls the dough. It mixes a product of clear white color and of smoother texture than it is possible to obtain by hand mixing.

Food is of the utmost importance to hospital patients, confined as they are through illness or accident. Especially is this true of those on restricted diets. Many of the ingenious mechanical devices on the market are helpful not only for the ease and speed with which they prepare vegetables and fruits for cooking and serving, but because they afford numerous possibilities for the unusual dressing-up of these articles of food. A vegetable that makes its appearance on the patient's tray in the shape of a rose, or potatoes cut in some novel way are more appetizing than when viewed in their natural form.

Patients and employees are vitally concerned with the dietary department and responsibility rests with this department to maintain the entire service on a high plane. It is well known that many patients base their judgment of the hospital on the quality of the food and the food service, and other benefits are apt to be lost sight of in their praise or condemnation, as the case may be, of this important item in hospital life. The dietary department should never be neglected or be allowed to operate without a full complement of equipment, as well as competent help and proper supervision.

Vegetable peelers may be had that can be operated either by hand or by electricity. They remove the skins from potatoes, turnips, carrots and other vegetables quickly, cleanly and with, it is claimed, about 10 per cent waste as compared with approximately 25 per cent waste when peeled by hand. While the skins are being removed from the vegetables, a stream of water is washing them. The water carries off the peelings and dirt through a drain pipe in the lower part of the machine which should be connected to a sewer opening.

Another type of machine combines the duties of cutter, slicer and cuber. It is designed to cut fruits or vegetables for cooking or for serving uncooked, and it is also useful in preparing salad ingredients, or for making slaw. It may be adjusted to cut potatoes in slices, French fry, Julienne style or cubes. There is also a machine that is said not to waste the juice or crush or bruise the fruits and vegetables in slicing them, and which is capable of cutting four articles of food at once. This slicer is equipped with four hoppers, and these may be filled with different ingredients for salads, preserved fruits or marmalades.

Ice cream is a popular dessert with patients. A power operated freezer is logical equipment. An electric freezer is made with an ice breaker mounted on the same base and driven by a connected motor. It is started and stopped



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—Rennin—the active principle in Junket—takes effect almost instantly when added to milk. As the milk coagulates, the first step necessary for its digestion is also accomplished. For this reason milk as junket is actually a more wholesome food than milk as milk.

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For the well

There is no more delightful dainty than junket. Served with nuts, fruits, whipped cream, or a fancy topping, it can be varied almost endlessly.

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Junket serves an additional purpose. It is listed by eminent physicians in many therapeutic diets recognized as standard. Particularly for malnutrition cases, there is no more valuable food available than junket. You will find authoritative diet information in our free booklet, "Junket in Dietetics."

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by a clutch, and so does not consume current when the breaker is not needed while the ice cream freezer is running. The amount of ice required by a hospital necessitates the installation of one or more ice breakers or crushers. These are generally power machines, although the hand operated breakers may be adapted to the requirements of the small institution. Ice may be broken for various purposes by changing the mechanical comb, which is designed to supply fine, coarse or extra coarse ice. Power ice cubers and shavers also have their place in supplying broken ice for filling ice bags, cooling drinking water for patients and staff or for freezing ice cream. Still other power freezers may be connected to a central refrigeration system thus doing away with the handling of ice and salt.

In the main kitchen we have interesting examples of the varied uses to which machinery may be devoted in preparing large quantities of food rapidly, economically and nutritiously.

In addition to the ranges, broilers, racks, tables, steam-jacketed kettles, roasting ovens, sectional steam cookers and other staple articles of kitchen equipment, there are a number of machines that are capable of performing much of the work of preparing the food for cooking and serving.

Mixing Machines Have Many Uses

Several general utility mixing machines that operate electrically are on the market, and these are indispensable to the hospital kitchen. These machines have been developed, in most instances, from mixers made originally for dough and cake mixing, and their range of usefulness has been greatly extended until today one of these machines is a small kitchen staff in itself. Not only does it mix all kinds of pastry and bread dough, but it mixes pie filling, mayonnaise and other dressings, whips cream and icings, beats eggs, custards and batters, strains soups, makes purées and smooth sauces from apples, cranberries and other fruits, mashes potatoes and performs other mixing, whipping and creaming duties. With the attachments that have been devised for these machines, it is possible to chop meats, slice or chop fruits and vegetables, grind cereals, cheese or crackers, make peanut butter, crumb bread, grind coffee or spices, sharpen knives and cleavers, polish silverware, and operate still other machines with the pulley attachment. A practical problem, in the use of these machines is to train employees as to the proper use of the attachments so as to reap the maximum advantage from it.

Mechanical potato mashers, when properly operated, are capable of turning out a product in which all lumps and hard pieces of potato are thoroughly broken up, and the potato becomes light and fluffy. The labor-saving advantage of these mashers over hand mashing is obvious. There are many chopping machines that will render good service. In one type of machine, the bowl in which the chopping is automatically done may also be used for mixing mayonnaise, as well as for cutting all kinds of meat and vegetables for soups, chowder or garnishes, crackers, cheese and other foods. This machine is a complete unit in itself and should not be confused with the larger utility machines. Other electric food choppers are made that can be operated exclusively as food choppers, or any one of several attachments, such as a coffee grinder, vegetable cutter, peanut butter machine or tool grinder, may be added to operate independently or synchronously with the food chopper.

Power coffee mills make it possible to have just the required amount of coffee ground for each meal, thus



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MIDLAND TILEOLEUM does more than remove the surface dirt, it seeks out the deeply imbedded grit and grime which escapes the usual cleanser.

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AMONG recent Ehler hospital successes—cited to illustrate the character and diversity of campaigns conducted under the Ehler **VOLUNTEER GIFT** plan—are the following:

Toledo Hospital, Toledo, O. (New hospital plant).....	\$1,600,000
Deaconess Hospital, Cincinnati, O. (Addition)	\$510,000
St. John's Hospital, Long Island City, N. Y. (Addition)	\$500,000
Deaconess Hospital, St. Louis, Mo. (Nucleus of new plant).....	\$360,000
Evangelical Home for the Aged, Brooklyn, N. Y. (Addition)	\$400,000

WE ARE now engaged in a campaign to raise a minimum sum of \$300,000 for the Shrine Hospital for Crippled Children, at Erie, Pa., and have been retained to manage a campaign for \$1,000,000 for the new Good Samaritan Hospital at Dayton, Ohio, where we have had two previous outstanding successes.

WE SHALL be glad to send you our booklet, "Institutional Financing," on request.

THE HERBERT B. EHLER COMPANY
TWELVE EAST FORTY-FIRST STREET
NEW YORK

conserving all the flavor and strength so necessary in making really delicious coffee. Mills can be purchased in a wide range of sizes and styles to meet various needs.

A mechanical can opener is very helpful and there is a machine so designed that it opens round, square and oval cans of any size from two to seven inches in diameter. By this method the entire top of the can is removed, which permits the complete emptying of the can without bruising or crushing the contents. This machine is sturdily built and simply constructed, and the cutting knife may be changed when it becomes dulled.

Presses for making jellies, fruit or meat juices, and lard, take their place in the mechanical equipment as adjuncts to the economical preparation of food. This point brings us to the consideration of a valuable item in the hospital kitchen equipment—the mechanical slicers for bread, meat, fruit and vegetables.

The fruit and vegetable slicers have been given consideration above, and their merits enumerated. A meat slicer usually provides a greater number of slices from a piece of meat than may be obtained by hand slicing. The slices are uniform in thickness and are not broken in cutting. The claim is made that by this method of thin slicing, meat is rendered more easily digestible. The thickness of the slices may be varied and adjusted as desired. These slicers can be purchased for either power or hand operation. Bread slicers have the same desirable qualifications for hospital service as the meat slicers, in that they save bread, the slices are uniform and unbroken, and the time-saving element again is of importance. Some of the slicers automatically stack the bread as it is cut, thus further saving time and labor. Protective devices against cutting off the operator's fingers are absolutely necessary and no machine should be considered unless it has this feature.

Equipment Needed in Milk Laboratory

In the milk laboratory the utmost care and cleanliness are required, as the preparation of infant feedings is often delegated to this department. The milk laboratory is also sometimes used as a teaching field for student nurses and student dietitians. Pasteurizers and cream separators may be needed in the larger institutions, depending upon the system followed. Another machine that might be indicated in hospitals operating their own dairies, is a milk can sterilizer washer. The can is first washed with hot water, sterilized by live steam, and then rinsed with clear cold water. Contained in a special type of sink is a milk bottle washing apparatus, in which the bottles are soaked in soda solution, cleaned by an electrically driven brush and rewashed in clean water.

It seems logical to consider paper goods in any discussion of labor-saving equipment. Paper dishes, finger bowls, drinking cups, tray covers, napkins and doilies are used, especially in some institutions for contagious diseases. They make possible a clean, sanitary tray service. It is possible to buy doilies and tray covers in lacy patterns—highly attractive to the patient's eye—that would be impractical in linen tray service, and these help to dress up the invalid's tray in a pleasing manner. The cost of paper service as compared to the usual methods is hard to estimate but is worth close investigation for cases of communicable disease.

The serving room of the modern hospital should be completely equipped with the latest devices for the rapid handling and serving of food, so that none of its delicacy or flavor may be lost before it is set in front of the patient, to whom each meal is an event in the midst of a round of nurses, physicians and medicine.

When everyone says,
"RIGHT!"

the idea must be a good one.
It's the "ZO" Hospital Spool,
adhesive plaster in new form,
a Johnson & Johnson
product.



A surprise awaits you—if you haven't seen
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It is the outstanding hospital specialty of the year. Endorsed by thousands! See the latest features, new container, etc., at Minneapolis. Our display there will include also a complete line of Johnson & Johnson prepared dressings for hospital practice.

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Johnson & Johnson
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A H A Convention
Municipal Auditorium
Minneapolis
October 10th to 14th

CELLU DIETETIC SCALE



Capacity, 1000 grams by 2 grams
\$6.50

Your patient will like this attractive, moderately priced food scale. Easy to use. Easily transported.

Construction: Dial of scale is non-rotating. A screw at the top adjusts for the weight of the dish, making computation unnecessary. A glass sash protects the face of the dial from spilled food and the hands from becoming bent. The body is made of steel with white enamel finish. Top of scale is removable.

Write for special hospital price lists

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INCORPORATED

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"ELECTRIC" HOSPITAL DUMBWAITERS



Push button control electric motor operated dumbwaiters provide the quickest, safest and most efficient way of handling the hospital food problem.

The "Electric" is safe, silent and costs very little to operate. The "Electric" is manufactured in a number of sizes with any type of push button control.

The "Electric" installed cost is surprisingly low. It is sold installed or F.O.B. factory. It can be installed by local mechanics from the very complete instructions and drawing we supply.

Let us send you our catalogue

DUMBWAITERS *"Electric"* DUMBWAITERS

ELECTRIC DUMBWAITERS INC.

BUFFALO, N. Y.

If there are cottages or outlying wings to be supplied from the central kitchen, food conveying boxes, either of the vacuum or hot water type, will prove helpful in transporting the food, piping hot. Insulated food conveyors equipped with rubber tired wheels which roll smoothly and quietly over the floors are built with four, six, eight or more compartments from which entire meals may be served. Each compartment is isolated and thus communicates little of its temperature to the other compartments. Cold foods stay cold; hot foods stay hot, and when the conveyor arrives in the ward, diet kitchen or serving room, as the case may be, the food is ready to be placed directly on the trays for immediate service. An individual box having several receptacles is also provided for private room or special diet service. It makes possible the serving from a distant point of a meal especially planned for an individual patient.

Food Conveyors Meet Need

Another type of insulated food conveyor is built so that it may be rolled wherever it is needed and plugged into an electric socket. This conveyor is so constructed that both hot and cold foods, or ice cream, may be placed in the conveyor at the same time, and the iced foods are not affected by turning on the electricity. The compartments for the cold dishes are separated from the other compartments, and are properly insulated to prevent the transmission of heat.

Both types of insulated food conveyors meet a genuine need in hospital service, and in some institutions they take the place of steam tables in the nurses' dining rooms or cafeterias. With this method of serving, if the meals may be served promptly, the food is in better condition than it would be if kept hot on gas or electric plates, and none of it is burned or dried out.

Because of the importance of orange juice in the patients' dietary an electrically driven fruit juice extractor is an important item in the hospital's mechanical equipment. It makes possible the easy and rapid extraction of the juice. These machines are said to extract about one-third more of the soluble solids and juice of the orange than it is possible to get if the juice is extracted by hand, and they do not press out any of the bitter oils contained in the peel, as does the ordinary fruit squeezer.

Then there are the beverage mixers that operate automatically by electricity. These are used to mix malted milk and other beverages and mix smoother and more palatable drinks than the old method of hand mixing, in less time. Another device having to do with beverages is a coffee creamer attachment that can be fastened to the coffee urn. It operates automatically, and its use results in a substantial saving of cream. If the faucet is turned to the left, it delivers black coffee; if turned to the right the proper mixture of cream and coffee is delivered instantly. The cream does not sour quickly because of a heat-proof insulation which keeps it at the temperature at which it was put into the container. This device will speed up service in cafeterias and dining rooms where it is not desirable to have cream pitchers on the tables. The only objectors are persons who prefer more or less cream than the mechanism provides.

Butter cutters and butter serving machines are convenient and may be kept sanitary. They do away with the old methods of hand cutting and serving with resultant saving of time. Automatic egg boilers and egg poachers eliminate guesswork, and insure the serving of perfectly cooked eggs—an item of importance in the patient's eyes. These cookers are operated automatically by electricity. In one type each timer has direct control

*The Nutritive Value
and Digestibility of
Red Label, Blue Label
and Orange Label are
Practically Equal*

KARO Syrup varies in color from crystal white to golden brown. The main difference between the widely known Red Label, Blue Label and Orange Label varieties is flavor or taste. Cane sugar or refiners syrup, likewise vanilla and maple flavor are present in limited quantities to satisfy individual preferences.

Karo Syrup is not all Dextrose, but this fully converted, quickly absorbable sugar comprises about 30% to 35% of its total (varying with the flavor or taste), the largest portion of the balance of the solids consists of dextrin—about 36%—which is an intermediate product of conversion between the raw carbohydrate and the complete Dextrose.



FOR CONVENIENCE THE SMALLER OR 1½ LB. CAN IS RECOMMENDED

Karo is the Corn Syrup now being prescribed for Infant Feeding not only because of its uniform high quality but because parents can secure it from grocers throughout the United States.

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KROME PLATE

Rust-Resisting
SURGICAL INSTRUMENTS

No Longer a Theory—Now a Proven Fact

OUR Krome Plate Instruments do outlast ordinary nickel instruments many times. Actual hard Hospital experience has now demonstrated it and some of the best rated Institutions are standardizing on it.

Many inferior imitations are appearing on the market. The above trade mark will protect you. We will replace any instruments that go wrong no charge.

The cost is only a trifle more than nickel plated instruments.

Every Good Dealer stocks them.

S. DONIGER & COMPANY

23 East 21st Street, New York City

Makers of

X-ACTO Syringe

(REG. TRADE MARK)

and X-acto Hypo. Needles made of V2A
Krupp Rustless Steel

See Our Exhibit at A. H. A., at Minneapolis, Booth 309

with the motor, which operates as soon as the eggs are lowered into the boiler and disconnects when the eggs are cooked the required length of time. The timer may be adjusted for varying periods of cooking, and at the end of the desired period, the eggs are automatically lifted from the boiling water.

Our consideration of labor-saving mechanical equipment in the hospital culinary department has led us by successive stages from the bakery to the serving room, and now we come to the problem of quickly and economically taking care of the soiled dishes, glassware and silverware which remain as mute evidence of our activities in the kitchen.

There are several different types of electric dish and glass washers from which to select the machine that seems best adapted to individual needs. The floor space that is available, and the capacity of the machine are two of the determining factors that affect a decision as regards the type of machine to be purchased. Some of these machines are of the conveyor type, in which the articles to be washed are placed on a conveyor that carries them through the sprays of wash water, rinse water, and in some cases, steam. Other machines wash the tableware, which is placed in baskets or racks, and carry it through the washer automatically. In other washers the racks are set into the circular drum of the machine, and the dishes, glasses and silverware are washed by the rotary action of the machine which forces the water up through the dishes, and its return action which carries the water down through the dishes.

Dishwashers Are of Various Kinds

In another type of machine the dishes are put into baskets that are placed in the oscillating cradle of the wash tank. They are removed from this tank after the tableware is thoroughly washed, and immersed in the rinsing tank of hot water from which they are lifted and placed on the dish table for drying. In all of these machines, the cleansing is quite thorough although dishes should all be inspected at the end of the process.

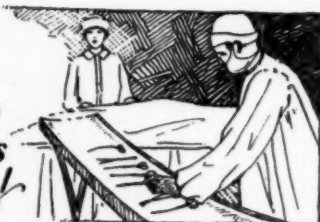
The dishes may be returned to the dish tables in a sanitary condition, where they will usually dry from the action of the air and the heat they have received while being washed. Hand drying is seldom necessary if rinse water be kept hot. The machines may be purchased in a wide variety of sizes. If the requirements of the institution are carefully studied, it will be possible to buy a machine that will care for the maximum needs of the hospital and save a great deal of the labor cost, as well as reduce breakage—a not inconsiderable item when dishes are washed by hand.

Electrically operated burnishing, polishing and buffing machines are obtainable. With one type of burnisher, labor cost is said to be reduced about 75 per cent. This machine consists of a wooden cylinder filled with many hundred thousands of steel balls and pins. The silverware is placed in the cylinder with soap and water, and as the barrel revolves the mixture rolls over the silver, between the tines of forks and down the spouts of tea and coffee pots. The silver takes on a lustrous finish, and it is claimed that by this method of burnishing, silverware does not have to be replated so often, which means a considerable saving. Smaller knife polishers with buffing attachments are also motor driven.

There are a number of metals now used extensively for the manufacture of kitchen equipment, table tops, utensils and cutlery that should rightfully be considered here because their physical properties class them with other labor-saving items. Their claim to recognition as labor-

WECK CRAFTSMANSHIP SERIES

No. 5 Old
Instruments
made New



WECK craftsmanship and specialization makes this statement a fact!

For years hospitals from coast to coast have been sending in instruments to Weck for repairing and reconditioning service. To the many who at first investigated, it was a revelation to have their old instruments returned after one week, fit again for the hand of the operating surgeon.

Weck Surgical Instrument Repair Service is far in advance of the field. A recent improvement named Chromium plating (known as "Crodon" to the trade) has been introduced, which plating only Weck is licensed to apply.

Chromium plating imparts an everlasting tarnish-proof finish to instruments, a finish nine times as hard as nickel and just as beautiful.

It protects against ordinary usage the specialized efforts of the Weck Master Craftsmen, who have shared in the process of reconditioning and repairing.

Your old surgical instruments will have new life, if "treated" by Weck Craftsmen, and then either Nickel plated or Chromium plated. Send in a trial lot "to investigate."

Surgical Instrument Repair Department of
EDWARD WECK & SON, INC.
135 Johnson Street, Brooklyn, N.Y.

for Infrared Therapy the BURDICK ZOALITES

For the application of heat use the Burdick Zoa-lite. In this highly efficient generator of Infrared rays you have the cleanliest, most convenient and most reliable method of producing heat, not merely superficially, but in the deeper tissues. You can maintain a constant degree of heat throughout the period of treatment.

The local action of the Zoa-lite is decongestive, analgesic and relaxing. The general action is sedative, restorative, eliminative and derivative.

In post-operative cases, treatment of the extremities is a splendid aid to the restoration of normal circulation.

The Z-12

This is the latest Zoa-lite model, a perfect bed-side lamp, with a specially designed inner reflector, making it adaptable for either local or general exposures. It is equipped with a 12" reflector and a 600-watt generator—the single-bar, cylindrical type, patented by Burdick. In grey lacquer. \$45.00.

The Z-30

Here is the largest of the Zoa-lites, designed especially for general irradiations in the hospital Physiotherapy Department. It is equipped with an 18" reflector and a 1500-watt generator. Stand has counterbalanced adjustment from 35" to 65" and cross arm with 15" extension. \$125.00.

THE progressive hospital of today has a well-equipped Physiotherapy Department where Infrared and Ultraviolet radiation prove splendid adjuvants to the classic methods of medicine and surgery. The hospital of the future will multiply today's advantages by bringing these modalities onto the floor. Every floor will be equipped with both Air-Cooled and Water-Cooled Mercury Arc Lamps. Every patient will be able to enjoy treatments with the Zoa-lite at his own bed-side on a daily or weekly rental charge.

Men who pride themselves on having the latest and finest equipment will be especially interested in the Burdick Exhibit at the American Hospital Convention in October. Our new modalities will be shown in Spaces 174, 175 and 176 in the Municipal Auditorium at Minneapolis.

for Ultraviolet Therapy BURDICK MERCURY ARC LAMPS

These highly efficient generators of Ultraviolet radiation have exclusive features that permit accurate measurement of dosage—and the development of a technic in which the only variable is the condition of the patient. No other equipment equals the Burdick series in this!

For general irradiations in treating rachitis, surgical tuberculosis and many dermatoses the longer rays transmitted by the Air-Cooled Lamps are indicated. They correct chemical unbalance in the blood stream, and normalize metabolism.

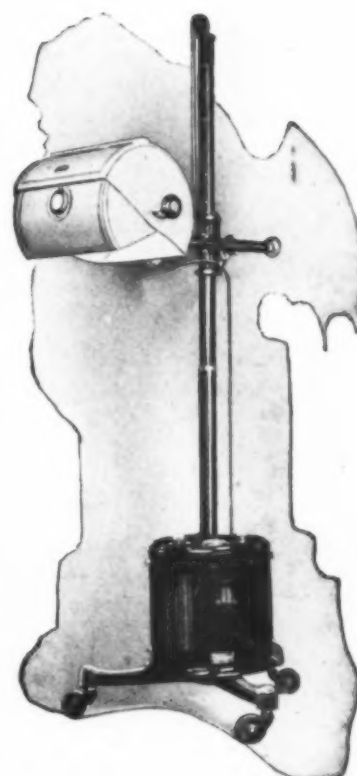
For brief intensive applications of the shorter wave lengths to the cavities and sinuses of the body you must have the Water-Cooled Lamps. These germicidal rays are invaluable in treating infections of the eye, ear, nose and throat, in genito-urinary diseases or in gyneciatrics.

Water-Cooled Lamps

Burdick offers a variety of models to answer every possible requirement of the medical profession. All are equipped with the Ever-Clear Quartz Window which raises the Ultraviolet intensity to a new peak and sustains it through hundreds of hours. Write for our booklet describing the Burdick Water-Cooled Series.

Air-Cooled Lamps

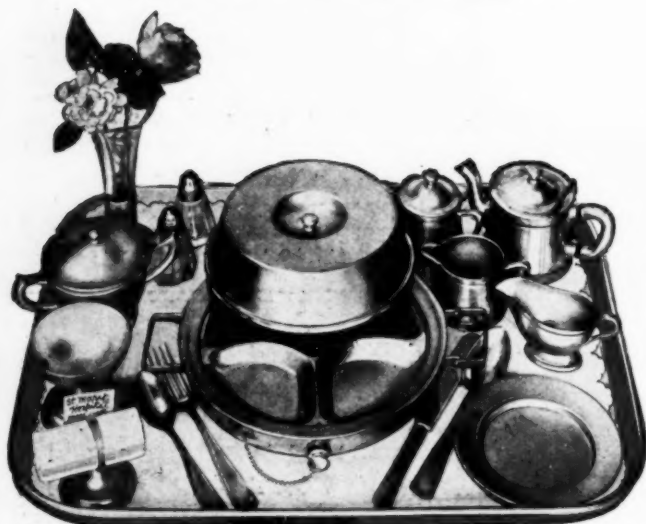
The Super-Standard Model (at the right) is equipped with voltmeter and voltage regulator for detection and correction of changes in the supply voltage. Uviarc high intensity quartz burner. Counterbalanced stand adjustable from 45" to 75" and swivel cross arm with 15" extension. Write for our folder describing this lamp.



The BURDICK CORPORATION
Milton, Wisconsin

LA-403—For Alternating current.
LA-103—For Direct current.

THORNER'S Silver Service



Thorner's Silver Service is made of 18% Nickel Silver with a quadruple silver plate. Wears a lifetime. Replacement through breakage is forever eliminated. It is never affected by wear or polishing.

Illustration features Thorner's Improved Three Compartment Hot Water Plate. Tea Set with reinforced bands, hard metal hinges, Silver Soldered and one-piece unbreakable bottom. Covered Soup Cup with Silver Soldered handles. Sherbet Dish, Gravy Boat, Individual Napkin Ring and Tray Marker, Bud Vase, Salt and Pepper Shakers and Superior Grade Sectional Plate Flatware.

AT THE A. H. A. CONVENTION
BOOTHS 225-226

THORNER BROTHERS

*Importers and Manufacturers of
Hospital and Surgical Supplies*

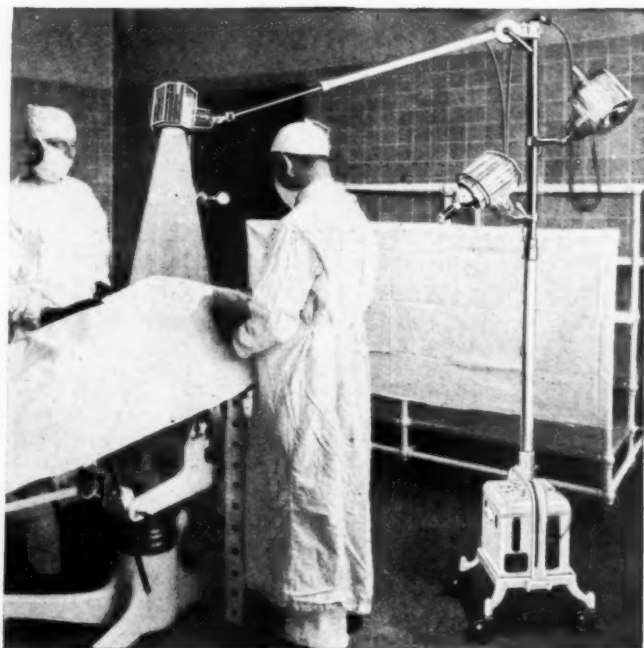
386-390 Second Avenue
NEW YORK CITY

saving equipment lies in the fact that they are strong and durable, easily cleaned, resist corrosion, are stainless or resistant to tarnish and retain a highly polished surface. Equipment manufactured from such metals has much to recommend it for hospital service and should be given consideration when purchases are being made.

In summing up the advantages of mechanical devices, whether hand or power operated, much is noted in favor of their general use. It must be understood that machines require constant care and are likely to go out of order at critical times, but in the present day of high labor costs and turnover they are nevertheless extremely valuable. The use of mechanical equipment, considered from the labor-saving point of view, reduces the number of employees required in the hospital kitchen. Wholesale methods of preparing foods offer little opportunity to cater to the atypical appetite. It is not desirable to try to eliminate human intelligence by the use of machinery, but such machines should be employed as will render human intelligence more effective. Against the adoption of machinery someone will perhaps raise the question of the high cost of the machines. The answer is that machines should be bought only after careful consideration and after the investment has been determined to be a wise one.

A NEW EVERDAY AND EMERGENCY LIGHT FOR THE OPERATING ROOM

A new operating room light that can be attached to a regulation light socket or to a storage battery unit has been recently placed upon the market. All of the three models are portable and give an intense light concen-



trated on the field of operation, the top arm being pivoted so as to be easily adjustable to any angle desired.

A storage battery built in the base of the machine makes these models emergency units as well as regular lights. They are so planned that should the current fail the light may be secured from the storage with practically no loss of time. The storage battery may be easily recharged by attaching it to the regular current through the medium of a specially designed charger.

Fresh Orange Juice

When You Want It

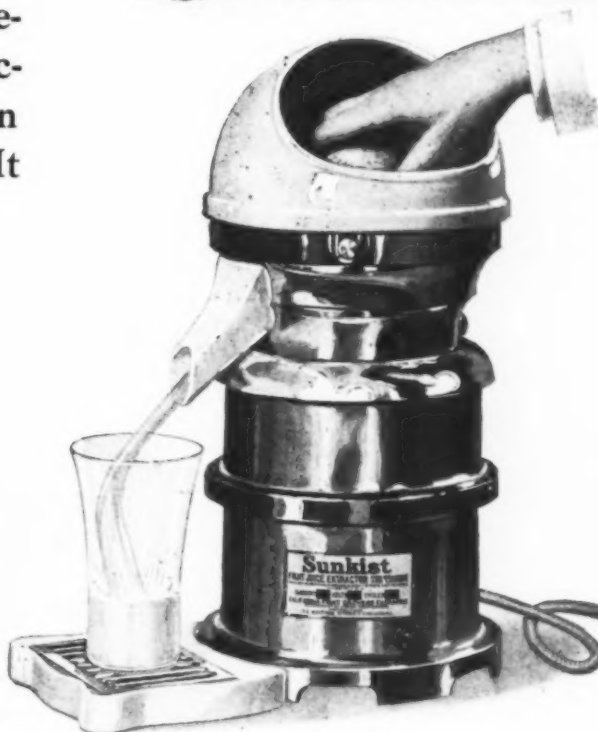
No Trouble—No Mess

NOW it's but a second's work to extract orange juice. No need to make it up in advance. Make it when and as you need it with the (electric) Sunkist Fruit Juice Extractor. It's quick, clean and economical this way. No waste—no muss.

Saves Time and Money

Hand squeezing is unsanitary and wasteful. It takes time. The Sunkist Extractor obtains from a box of oranges an added gallon of finest golden juice. It saves one-third on your fruit bill.

There are many other important features to this amazing little machine. Coupon will bring you all information on cost price offer, easy terms, etc. Mail it now.



MAIL THIS COUPON

**California
Fruit Growers
Exchange**

Div. E-710

154 Whiting St.

Chicago

California Fruit Growers Exchange,
Div. E-710, 154 Whiting Street,
Chicago, Ill.:

Without obligation, please rush me information regarding the Sunkist Fruit Juice Extractor.

Name

Street

City State

OUTLINING A NEW TECHNIQUE FOR NURSING SCHOOL CURRICULA

(Continued from page 152)

There is no nursing school in New York State, I believe, that gives in its whole curriculum as many hours of teaching as any good medical school gives to a single subject, such as anatomy. The main criticism which we get from our own graduates and from educators of all types in regard to the nursing curriculum is on this excessively high proportion of practice in relation to theory, and the superficial character of most of our courses, the science courses especially.

While the children in our public schools and the general adult public are urged to take courses in general science, our nursing courses are being rigidly scrutinized to see that the nurse does not get more than homeopathic doses of chemistry or physiology or bacteriology or any scientific subject. And yet she lives in the heart of what is supposed to be a scientific institution and has an important and responsible share in all its work. It is contended by some of our critics that the reason for this is that too much scientific knowledge is apt to make the nurse less practical, and to spoil her fine spirit of service. If this is the effect of a little science on the nurse, why are other workers not affected in the same way? Such statements must be proved before they can be taken seriously by those who have the nurse's interests at heart.

When it comes to the planning of class work and practice work, a good deal might be said about the various arrangements and their advantages, from the educational as well as the practical point of view. We should all agree, I think, that the knowledge which illuminates and guides the student's practice should come as nearly as possible at the time when she feels the need of it, and when her interest in it is keen. If this is not possible, it should come a little in advance of the practice in order to save her from making blunders which may endanger her patient and may expose the hospital to serious criticism. This is why we try to concentrate more of the theoretical work in the nursing curriculum in the early part of the course. There is an economic advantage also, because the young student is much less valuable to the hospital than when she has covered her basic science and has gained some skill in practice.

Case Study Method Best

Later, when she is ready to take up her regular duties in the hospital wards, she must concentrate more on the study of disease and its symptoms, and on treatments, diet, medicines, and all kinds of records and reports. It is important that theory and practice should run close together here, and the best method of teaching is undoubtedly the case study method supplemented by lectures and clinics, and constant teaching supervision in the wards.

We have the opportunity here for the finest possible kind of educational work. Other students and teachers envy us this incomparable laboratory with its wealth of human material and its vitally interesting problems. But with the pressure of work and the increasing complexity of hospital service, I do not see how it is possible for head nurses to give more than the most fragmentary kind of teaching in the wards. We shall have to bring in a larger teaching staff and free the students from more of the routine of ward work before we can hope to get good results from this kind of instruction.

I should like to say a word in answer to the criticism



BATHROBES

THERE is an established demand in hospitals for a bath robe combining neat appearance, durability, satisfactory laundering qualities, and low price. Though neat in appearance it should be of quiet color. These are qualities that the ordinary bath robe designed for retail trades does not provide. Our bath robes are designed especially for hospital use. They are tailored, big and roomy, with neat turnover collar, long, coat style sleeve, string belt made of same material as robe, and with frogs on adult sizes and buttons on children's sizes. Made in adult sizes small, medium, and large. Children's sizes six to fourteen years.

F113-A—Adult's Robe. Plain gray twill flannel. A very fine value.

Per dozen . . \$29.50 Each . . \$2.75

F113-B—Adult's Robe. A light weight Scotch flannel. Gray with black stripes.

Per dozen . . \$22.50 Each . . \$2.00

F113-C—Adult's Robe. As illustrated but with roll collar. Substantial Terry cloth.

Per dozen . . \$46.50 Each . . \$4.00

F113-D—Child's Robe. Made of gray twill flannel.

Price according to size.

Write for Quotations

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WHOLESALE HOSPITAL SUPPLIES
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AT THE
MINNEAPOLIS
CONVENTION
Booth No. 220

Nursery NAME NECKLACE

Baby Identification

VISIT OUR EXHIBIT
BOOTH NO. 235

At the American Hospital
Association Convention,
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Oct. 10-15, 1927.

*Why Not
Protect Those
Intangible Ones, Too?*

You insure your buildings against fire; your valuables against theft; and your institutions against liability; you take out life insurance to protect your family; and accident insurance to protect your income. *Certainly, you believe in protection. You use it for your tangible values.*

How about the *intangible valuables* of your institution and your administration? Do you safeguard them in every possible way? How about your obstetrical nursery, where positive modern infant identification will protect the

HOSPITAL	Good Name
OBSTETRICIAN	Record
NURSE	Career
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BABY	Identity

May we send you illustrations, descriptions, prices and terms of the Nursery Name Necklace—the baby identification that is *sure*. Remember no one ever *lost* by seeking knowledge and many have *gained* and *saved*.

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222nd STREET
QUEENS VILLAGE (L. I.), NEW YORK



Need Money for a New Building?

EVERY hospital has in its executive positions trained specialists. Such persons accomplish more in less time than others.

The same principle applies to raising money. Specialists raise more money most economically.

Hedrick, Marts & Lundy have had experience raising money in many cities from the Atlantic to the Pacific. They have obtained large sums for new hospitals, for additions to old equipment—or to clear off accumulated debt.

Campaigns undertaken anywhere. All the many details are carefully directed by our experienced staff.

Tell us your plans.

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Member Joint Board of Campaign Counsel and Planning

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They use it too!

Henry Ford Hospital

The Henry Ford Hospital, at Detroit, is another of the many hospitals using National Die Marking Machines.

Marking Linens and Uniforms.

For quick, easy, permanent marking of all linens and uniforms, use a National Die Marking Machine—it assures you of full, permanent identifications, thereby protecting you against the usual linen and uniform losses.

Made in several models to accommodate dies ranging in size from 2x½ inches to 4½x2¼ inches. We cheerfully submit original sketch of die design for your approval.

Send for literature and prices.

The National Marking Machine Co.

4042 CHERRY STREET

CINCINNATI, OHIO

that there is too much medical content in the average nursing curriculum. In the first place, we must agree that both nurses and doctors have to deal with sick people, and they must therefore understand something of the human body in its normal workings and also something about the processes of disease. The physician needs a different kind of knowledge, assuredly, and a more extensive knowledge about disease, but so long as the nurse is carrying out treatments, observing symptoms and fighting infection, she must understand what she is doing and why she is doing it.

Many of the terms used in the nursing curriculum are the same as those used in the medical curriculum, but that does not mean that we teach the same kind of things in a nursing school as in a medical school. The physician puts his own interpretation on these terms and the nurse puts hers. Indeed one of the criticisms we hear most frequently about the medical teacher is that he cannot quite see the thing from the nurse's point of view and often gives a great deal of medical detail that she does not need and does not want.

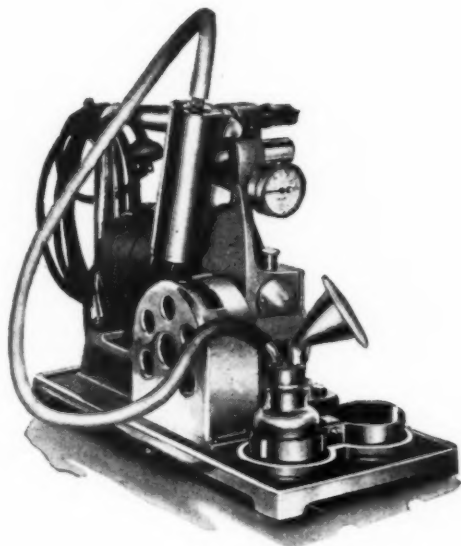
Nurse Must Know Modern Viewpoints

But the nurse must know in a general way what is going on in medicine if she is to cooperate with the physician in his work. It is the proud boast of medicine that it has advanced more in the last fifty years or so than in all the centuries before. If that is true, is it not reasonable to expect that the nurse must travel rapidly, too, if she is to keep pace with all the newer methods and with the newer points of view in the general field of health work? No physician or patient wants a nurse who is a "back number," but how can she be up to date without reading and studying and experiencing these things? She cannot absorb them from the physician by the process of osmosis or pick them out of the atmosphere by the force of chemical attractions. She must learn them through the ordinary processes of education.

Another point to remember is the constantly shifting division of duties between medicine and nursing. Procedures that were formerly definitely classed as medical are constantly being handed over to the nurse. I am not sure that she is always right in assuming these added responsibilities, but surely if she is expected to carry them, she must also receive instruction that will enable her to carry them safely and well. Whenever we place added responsibility on anybody, we must be prepared, in all fairness, to give the additional knowledge needed for assuming the responsibility.

In regard to the length of time required for the basic course in nursing, I do not think any hard and fast rule can be made. It depends on so many different factors, on the ability of students and the kind of preparation they bring, on our conception of what education means, on the facilities which the school can provide for teaching and supervision, on the amount of noneducational work which goes into the practical experience and the amount of time that can be given to actual teaching. The only way in which time can be saved in the educational process without endangering the product is through better preliminary preparation, better teaching and less wastage of time in things that don't count professionally or educationally. If it is agreed that students must work their way through the hospital in order to pay for their tuition and maintenance, that is an economic problem, but don't let us try to deceive ourselves or to convince them that all this extra hospital work is necessary for their education or for their moral development. They are really not deceived by these elaborate rationalizations of existing practice, or by the

Ask Your Friends at the Convention



AN outstanding feature at the American Hospital Association Convention, will be the exhibit of the Perfection Breast Pump at Booth 282. Many who have heard of it will welcome this opportunity to see it and talk to others who have it in use.

The Perfection Electric Breast Pump provides an aseptic method of milk expression that saves much valuable time for the nurse and relieves them of much arduous work. It is invaluable for the following uses:

1. Development of breast milk.
2. Relief of engorged breasts.
3. Correction of inverted nipples.
4. Treatment of fissured nipples.
5. Re-establishment of milk in dry breasts.
6. Stimulating the secretion of milk and maintaining an adequate supply.
7. Combating the promiscuous use of "patent" baby foods.

Write, now, for our catalog which explains some of the special features in the Perfection Breast Pump or ask us to send a Breast Pump to you on approval.

Those attending the Convention are cordially invited to visit us at Booth 282 and at our Factory.

Here Are A Few Of The Many Hospitals That Use The Perfection Breast Pump

Anderson, Ind.	St. John's Hospital
Bronx, N. Y.	Hunts Point Hospital
Brooklyn, N. Y.	Victory Memorial Hospital
Charleston, W. Va.	Charleston Gen'l Hospital
Chicago, Ill.	St. Anthony de Padua
Cortland, N. Y.	Cortland County Hospital
Detroit, Mich.	Evang. Deaconess Hospital
Detroit, Mich.	Florence Crittenton Home
Detroit, Mich.	Providence Hospital
Duluth, Minn.	St. Mary's Hospital
East Orange, N. J.	Homeopathic Hospital
Elizabeth, N. J.	Elizabeth General Hospital
Grand Forks, N. D.	Deaconess Hospital
Hackensack, N. J.	Hackensack Hospital Assn.
Holyoke, Mass.	Providence Hospital
Lansing, Mich.	St. Lawrence Hospital
Lansing, Mich.	Sparrow Hospital
Lexington, Ky.	Good Samaritan Hospital
Los Angeles, Cal.	California Luth. Hospital
Lowell, Mass.	Lowell Corp. Hospital
McKeesport, Pa.	McKeesport Hospital
Middletown, Conn.	Middlesex Hospital
Minneapolis, Minn.	Deaconess Home Hospital
Minneapolis, Minn.	Eitel Hospital
Minneapolis, Minn.	Fairview Hospital
Minneapolis, Minn.	Hillcrest Hospital
Minneapolis, Minn.	Northwestern Hospital
Minneapolis, Minn.	St. Barnabas Hospital
Montclair, N. J.	St. Vincent's Hospital
New York City	Knickerbocker Hospital
New York City	Lying-In-Hospital
New York City	Sloane Hospital for Women
Niagara Falls, N. Y.	St. Mary's Hospital
Philadelphia, Pa.	Jefferson Hospital
Phoenix, Ariz.	St. Joseph's Hospital
Pontiac, Mich.	St. Joseph Mercy
Portland, Maine	Maine General Hospital
Racine, Wis.	St. Mary's Hospital
St. Louis, Mo.	Missouri Baptist Sanitarium
St. Louis, Mo.	St. Louis Maternity Hospital
St. Paul, Minn.	St. Paul Hospital
Seattle, Wash.	Seattle General Hospital
Seattle, Wash.	Swedish Hospital
Sioux City, Iowa	Maternity Hospital
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**MODERN
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are enthusiastic in their ap-
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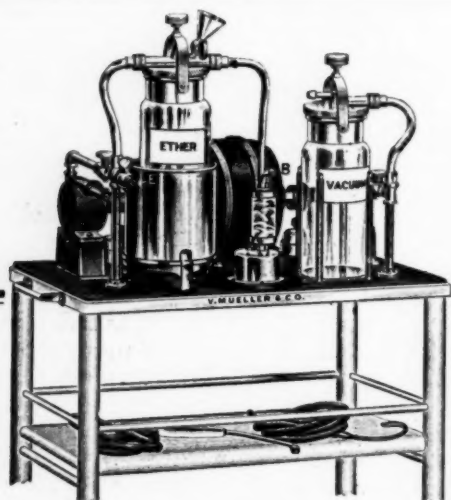
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padding assignments of hospital duty which we are often
at such pains to disguise as education.

Before we go too far in reconstructing the nursing
curriculum, it might be well to get the point of view of
the students themselves, and perhaps more especially the
opinions of potential students in our high schools and
colleges who are now making up their minds whether they
want to go into nursing or into some other field. These
young women are quite modern, that is, they are more
critical and less easily humbugged than young women
used to be. They have much wider opportunities than we
had twenty or thirty years ago, and moreover, all kinds
of occupations are bidding for the best of them and will-
ing to pay quite a high price to get them.

How can nursing schools compete with all the modern
professional schools and with the colleges which are now
crowded to the doors and overflowing? Some of these
girls who a few years ago would have gone into nursing
are now going into medicine because nursing does not offer
them the kind of education they want. Some who would
formerly have chosen nursing are going into social work
or into nutrition work or home economics. No one talks,
in any of these fields, about the dangers of over-training,
and the advisability of cutting down the curriculum to the
lowest possible minimum. No one seeks to limit arbi-
trarily the contribution which these professions have to
offer or insists that it takes only mediocre brains and
little education to succeed in them. It is all the other way.
Every effort is made to dignify the work, to show the
opportunities for advancement and to convince the student
that she cannot be too capable or too well prepared for
the thing she is trying to do. If we are interested only
in securing students for our schools and not in nursing
education at all, we use very poor publicity methods to
reach our potential customers, when we so deliberately
cheapen the thing we have to sell.

We are constantly assured that nursing is a profession
but we have never really put it on a professional basis
either educationally or economically. And until we do
that we cannot expect to attract the number of persons
we need or the kind of persons we need for nursing serv-
ice. Moreover we cannot expect to get the best kind of
nursing service. No curriculum, however good, can do
these things for us, but it can do a good deal if we supply
the right kind of human material and the right kind of
environment, a good teaching force and other educational
resources.

I do not see how any of these things can be done well
without better financial support than these schools have
had in the past. I doubt whether hospitals should be
expected to maintain schools at all unless they can secure
adequate funds for this work. Sooner or later the public
must assume responsibility for this branch of education,
as for all other branches where public service is involved.

DISTINCTIVE CHARTING SYSTEM SIMPLIFIES RECORD KEEPING

A special chart of distinctive green color has been in
use at the Chicago Municipal Tuberculosis Sanitarium,
Chicago, since January, 1927, to designate the "contact"
case in the files. The green chart, against the background
of the ordinary manila charts, immediately identifies the
case as having been in contact with an open or active
case of tuberculosis. These specific green charts render
the compilation of contact statistics very simple, and
within the course of a few years will furnish exceedingly
valuable and accurate information.

“MAKES A FIRE TELL ON ITSELF”

FIRE!

Fire Inspector Starts Blaze in Hospital, Alarm Tells of Deed

They started the fire with three helpless, new-born babes in one adjoining room and six bed-ridden patients in another. And not one of the group, which included a fire inspector, raised a hand to stop the blaze, which was set in the dining room of the Essex Private Hospital at Thirteenth and Fairmount avenues yesterday.

As a matter of fact, it was the fire inspector who touched the match to the big tray of alcohol of the wood variety.

A minute, fifteen second after the first blotch of flame leaped up, the fire gong sounded its ominous warning, the one dreaded noise of a hospital. Yet no one moved. Rather, broad grins of satisfaction spread over the features of those who watched this bold incendiarism.

It was a test of a new wiring

system, installed throughout the building as a precautionary measure urged for such institutions by Building Inspector Bigelow. Whenever the temperature of any room reaches 160 degrees, the alarm is automatically turned in, and it was under the supervision of Inspector William Gibbs of the Bureau of Combustibles and Fire Risks and William Fiverson, structural engineer, division of buildings, Department of Public Safety, that the test was made.

The wiring was done by the Garrison Fire Detecting System of New York. Yesterday's test was witnessed by W. D. Lindsey of South Orange, vice-president of the company. Dr. David N. Shack, president of the hospital, and Miss Dorothy Marie Maykish, nurse, also were present for the experiment.

FROM
NEWARK,
N. J.
NEWS,
AUG. 31,
1927

Garrison experts will gladly make a survey of your premises and submit a detailed specification and estimate—at no expense or obligation on your part. We are at *your* service.

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DePuy Manufacturing Co.
Warsaw, Indiana

AVOID STRUCTURAL ERRORS AND INCREASE DIETARY EFFICIENCY

(Continued from page 158)

washed, where this might not always follow if he had to walk some distance to a sink. J. O. Dahl, *Hotel Management*, New York, says that it should be possible for a cook to get 90 per cent of what he needs without taking more than two steps.

In summer all outside doors and doors leading to other parts of the house, and all windows that can be opened, should be screened with mesh that is fine enough to prevent mosquitoes, young flies, and other small insects from getting through. These screens should be so made and adjusted that they may be readily removed for cleaning. Awnings should be provided for windows that are exposed to the sun, so that the heat from within, which cannot be avoided, should not be intensified by heat from without, which can be avoided. A screened enclosure for garbage cans is helpful in combating the fly problem. Compartments built in the wall, with openings inside for receiving the garbage and provision on the outside for its removal, afford a convenient method of disposing of the garbage and at the same time solve the problem of keeping it out of the kitchen.

Natural ventilation is desirable for the comfort of workers, but it is not generally sufficient to carry off odors and heat from the ranges and other large cooking equipment. Mechanical ventilation is necessary to prevent odors penetrating to other parts of the hospital. Hoods over the cooking equipment help much in this respect, the vents of these hoods carry off the heat and vapor in their vicinity, and to some extent reduce the temperature of the room. Heat, vapor, and odors not exhausted by this means rise to the top of the room. If ventilation of these upper spaces is not provided the room becomes very warm, especially in summer, and the deposits of grease on the ceiling and upper walls necessitate frequent cleaning, which is not ordinarily easy to carry out. Lining hoods with glazed tile is a justifiable expense, because of the greater convenience in cleaning and the improvement in lighting. Good lighting is essential to good work beneath the hoods and may promote cleanly habits among the workers.

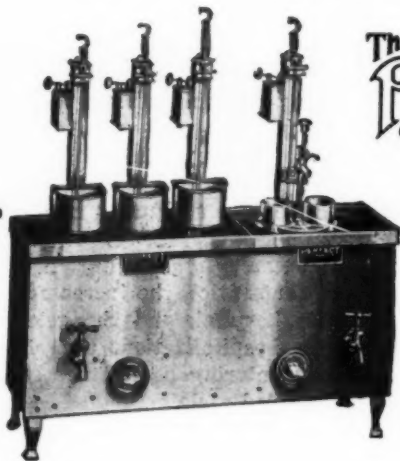
Mechanical Ventilation Necessary

A more desirable form of mechanical ventilation is having individual vents from the cooking equipment extending through the floor and connecting with a vent duct which exhausts the air by gravity. Smoke flues may be carried through the floor. This does away with all hoods, thus eliminating much cleaning, and gives a more pleasing appearance to the room.

Flat top ranges are an economy regardless of the kind of fuel used, as more space is available for utensils and less heat is wasted. Separate ovens are better than those either above or below the range. Ovens above the range require a great deal of lifting; those below are equally difficult because they necessitate stooping, particularly in handling roasts and other heavy things. In the one case, a great deal of heat is thrown off on the head and face; in the other, the feet suffer. With the separate oven these difficulties are lessened; then, too, more space is available within the oven. These may be had for either gas or electricity.

A refrigerator for the cook's use, placed near the center of his activities, will more than pay for itself. Perishable things such as butter, milk, cream, fruit, will be better

Making the hospital dollar go twice as far!



The Perfect
AUTOMATIC
EGG
TIMER
POACHER
BOILER

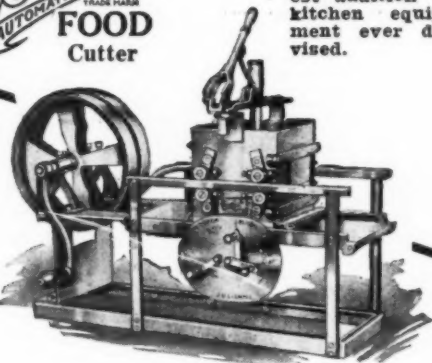
Combined
Egg Poacher
and Boiler

IN the boiling and poaching of eggs—*automatically*—the Perfect Automatic Egg Poacher and Boiler not only saves time and labor in the kitchen but guarantees *uniformity* and *exactness* in timing—and lowers fuel costs. Each compartment is entirely separate. Either gas, steam or electric types are available. This nationally known equipment is standard in most hospitals. Get complete information from you jobber or write us direct.

The Perfect
AUTOMATIC
FOOD
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Without question, the greatest addition to kitchen equipment ever devised.

Cutter,
Slicer,
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Entirely automatic! Simply fill the hopper and turn the handle. Cuts any desired shape, size and thickness *at one time!* Unusually wide knife edges for speed; hardened roller bearings for ease and quietness of operation. A time- and labor-saver without a rival. Write us for prices and complete description.

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People misuse laxatives

YOU are doubtless familiar with the patient who keeps a supply of pills on hand and doses himself by his own prescription—usually employing increasingly stronger pills, with detrimental effects.

Far too few sufferers from constipation realize that faulty elimination can be naturally relieved by proper diet. And so the pill-habit claims its thousands year after year.

Kellogg is helping to wipe out this misuse of laxatives by publishing the truth about bran the country over. We are proud of the support and approval the medical profession have given to Kellogg's ALL-BRAN.

ALL-BRAN is 100% bran. That is why it is so much more effective than part-bran products. Why physicians can rely upon it to accomplish the definite results anticipated.

And ALL-BRAN is a prescription patients like to take. Delicious with milk or cream—and with fruits or honey added. It is equally efficacious when used in cooking. Made by Kellogg in Battle Creek. Sold by all grocers.

Kellogg's
the original
ALL-BRAN
ready to eat

Vita Glass

transmits the *shorter* ultra-violet rays that build health

Only a portion of the ultra-violet radiation from the sun has definite health value. This vital health range, scientists and medical authorities have proved, lies in the shorter ultra-violet wave-length from 2910 to 3200 Angstrom Units. These are the rays that tan the skin. They have unusual tonic and curative value. They increase the red corpuscles and the hemoglobin. They improve appetite, nutrition, and metabolism. They act as a bactericide and strengthen resistance to disease. They are invaluable in the treatment of a rachitic condition in children.

Ordinary window glass admits the *longer* ultra-violet wave-lengths, from 3900 A. U., where visible light in the sun's spectrum begins, down to 3200 A. U. But it shuts out the healthful *shorter* wave-lengths below 3200 A. U. You cannot become tanned from sunlight that has been filtered through ordinary glass.

Three years of practical tests have proved that the Vita glass already in use does transmit the vital health range of ultra-violet rays. For further protection, every batch of Vita glass that leaves the factory has been subjected to rigid tests and is guaranteed to have high transmission quality.

Today, there are sixty hospitals and sanatoria that use Vita glass or have ordered it installed. A growing list of users includes hotels, apartments, office-buildings, schools, and private homes.

Beyond the word Vita etched in a corner, clear Vita glass looks like the usual window glass. Cathedral Vita glass is translucent and enables patients to take sunbaths without embarrassment. Both are supplied, cut to specification, ready to install.

We will be glad to tell you about Vita glass in detail. The coupon below is for your convenience.

VITAGLASS CORPORATION,
50 East 42nd Street,
New York City.

M.H.10

Please send me full information on Vita glass. I am interested in using Vita glass for.....

Name

Address

City State.....

cared for, and there will be less inclination to disregard small amounts of food left over after the meal is served, also a greater inclination to use these left-overs if they are conveniently near.

Equipment, such as cupboards, sinks and work tables, is distinctly an individual problem in each department and should be planned to meet the requirements of the work to be done in each case. Metal cupboards and cabinets became popular a few years ago. If these are well made they are satisfactory, but many cheaply constructed cabinets were put on the market, in which drawers sagged and doors warped, creating an annoyance as well as being noisy. However, properly constructed metal cabinets do not have these faults; they are vermin proof, and easily kept clean. Manufacturers of kitchen equipment are constantly improving their products and producing new ones. One noticeable illustration is the work table. Metal tops for these tables is now the rule.

With better facilities for service, the increased interest of the community in its hospital, and the greater confidence of the public in hospitalization, the small and medium sized hospital is entering a field for service in which it has as yet only "filed a claim."

HOW TO MAKE DIET TRAYS ATTRACTIVE

To make special diets and all trays attractive, the nurse must appeal to the three esthetic senses—smell, sight and taste, says Grace T. Sharpe, formerly dietitian, Loomis Sanatorium, Loomis, N. Y., in an article on the feeding of the tuberculous patient in a recent issue of the *Trained Nurse and Hospital Review*. Make hot foods hot, and cold foods cold, is the first commandment of good food service. Stainless silver, spotless linen and sparkling glass, are corollaries that are not insignificant. In institutions regularity of tray service achieved through the cooperation of the nurses is the second commandment which governs satisfactory service.

To appeal to the sense of color the trays may be of wide variety. Stimulating reds may be achieved by the use of tomatoes, beets, berries, pimentos, cherries; orange from carrots, apricots, peaches, oranges; yellow from eggs, butter, corn, pineapple; green from lettuce, peas, peppers, beans, asparagus; blue from grapes, blackberries and prunes. This makes a whole rainbow of color with which to decorate each day's tray.

To carry out any color scheme without confusion, demands a well directed and keenly interested staff in the kitchen. For sick people too great stimulation of the sense of smell is not always desirable. On the other hand the freshness of any dish and a sufficiently faint odor to stimulate the flow of gastric juices is always advisable. Variety of taste and texture is welcome where the diversity of the diet permits. The institutional worker must depend upon her staff for this attention to detail. Fresh lettuce, crisp toast, smooth soups, freshly creamed vegetables, well browned steak, are all high points for a desirable meal. To direct her staff well the dietitian must first know her own ability and inability, second she must know her staff and third she must plan accurately what work is to be done. Satisfactory management also depends upon the nature of the work, the conditions under which it is done, the labor saving devices available, the wages and the amount of relaxation allowed.

Finally, economy of service is based upon feeding the patient in a way that proves satisfactory to him. To do this the nurse and dietitian must know his nationality, his former eating habits and his individual tastes.

The Memoirs of Dr. X.

Case records are in the ultimate only the memoirs of him who writes them. Real records should be of facts, understandable to all and without ambiguity.

Photographs meet these desiderata completely. And with modern equipment are quickly, easily and cheaply made by all. There is no good reason why they should not be extensively used to illustrate case reports. That photographs make for better reports, save the time of internist and save money are conclusive reasons for using them.

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No hospital is completely equipped
which lacks modern photographic means.

Eastman Kodak Company

Medical Division

Rochester, N. Y.

To meet the requirements of various therapeutic diets —easy, tempting dishes

After the physician's diagnosis is made, it is the dietitian's problem to meet the diet's requirement in a way to satisfy both physician and patient. And most dietitians prefer to use one standard food, if possible, in doing so.

There is a standard food which physicians advise in some form for almost every patient, because it is so high in carbohydrate content and so easy to digest. Dozens of tempting dishes may be made with it as a base. That food is Cream of Wheat.

Patients are pleased because, in addition to the many attractive ways in which it can be served by itself, Cream of Wheat has the added advantage of blending deliciously with other foods. Combinations with fruits—fresh or stewed—with vegetables, with meats. And the buying budget is not strained. Every box has 40 generous servings.

Not only is it economical to *buy*, but it is economical to *keep*. Triple-wrapped-and-sealed, there is no possibility of spoilage.



There are a lot of fine recipes for these interesting combined food dishes in our little booklet, "50 Ways of Serving Cream of Wheat." Send for it. It is free.

FOR 30 YEARS A STANDARD FOOD ON
PHYSICIANS' DIETARY LISTS

Cream of Wheat

Cream of Wheat Company, Minneapolis, Minnesota
In Canada, made by Cream of Wheat Company, Winnipeg

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FEATURES THAT DISTINGUISH GROUP CLINICS

(Continued from page 162)

tained a diagnostic cross-index file, by various combinations, using the nomenclatures of the Massachusetts General Hospital, Boston, the Bellevue Hospital, New York, the United States Public Health Service (International), or the University of California.

Medical social service was not represented as such, either in name or in a technical sense at any of the private group clinics. The Mayo Clinic maintains its own so-called general service, which is assigned to take care of arriving patients, arrange for their needs, furnish wheel chairs or ambulances. Rooming and boarding houses are listed with a woman Y. M. C. A. secretary, who has a desk within an enclosure at the center of the main waiting room.

Two Social Workers Employed

In this same enclosure are desks for two social service workers whose duties pertain largely to home communication service, making financial arrangements for patients who need hospital treatment or operations, getting in touch with their families and friends at home. A centralized social service department is maintained in the basement of one of the affiliated hotels, at a point some distance from the clinic building. Arrangements for hospitalization are made through the hospital assignment office, which has an office adjacent to the main waiting room.

At the Cleveland Clinic little was said about any medical social service. Here again some worker was employed largely to take up financial adjustments and cost of hospital treatment and operations.

In other group clinics, in connection with the non-medical personnel, such as registration clerks and similar functionaries, much emphasis was placed upon a knowledge of human nature and human understanding, tact, and good sense in meeting problems and considering complaints. One such clinic had adopted a plan of meeting its own needs by establishing a training course for office attendants, taking girls who had recently been graduated from college or who had at least completed a business course following high school.

A CHECK ON AUTOPSIES

At the Hermann Hospital, Houston, Texas, a form has been devised that is used as a check for autopsies. The form, which is here reproduced, is filled out for each patient who dies in the hospital, and is attached to the history. It serves as a record to show that an effort has been made to get an autopsy permit for each patient who dies, that an order has been given to turn the body over to the undertaker selected by the relatives and is signed by the undertaker.

Houston, Texas.....192.....
I.....bearing the relation
of.....to.....the
deceased do.....authorize the authorities of Hermann Hospital
to perform an examination of the body of said patient and to remove
such organs as may be necessary to ascertain the cause of death.
.....Undertaker is hereby
authorized to call for the remains at.....a. m.—p. m.
.....192.....

Witness:

Received from Hermann Hospital, in good condition, the remains of
.....192.....

UNDERTAKER

Per

HOSPITAL SUPERINTENDENTS

And all others interested in Aseptic Metal Furniture for Hospitals are cordially invited to visit our Booths Nos. 120 and 121 at the American Hospital Convention in Minneapolis.

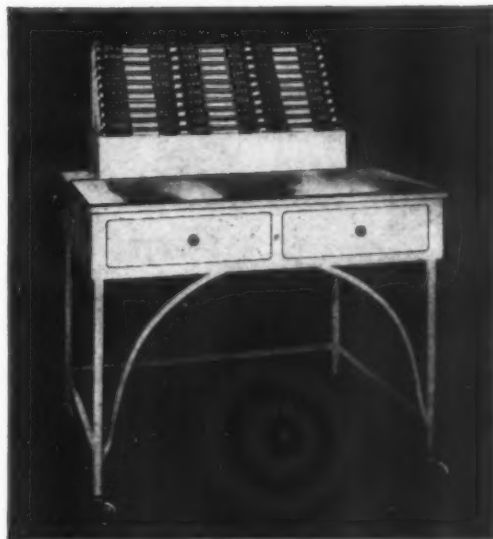
Here will be exhibited the following:

Ohio Operating Table No. 2.
Visible Clinical Chart Desks.
Combination Bedside Tables.
Delivery Bed, Supply Cabinet.
Bassinettes, Chairs, Stools, etc.

You will be most welcome and we shall be glad to see you.

Write today for prices

F. O. SCHOEDINGER *Manufacturer* Columbus, Ohio



Visible Clinical Record Chart Desk C.A.6

32 in. high, 37 in. wide, 19½ in. deep

To Hold Thirty Special Noiseless Aluminum Book Form Chart Holders

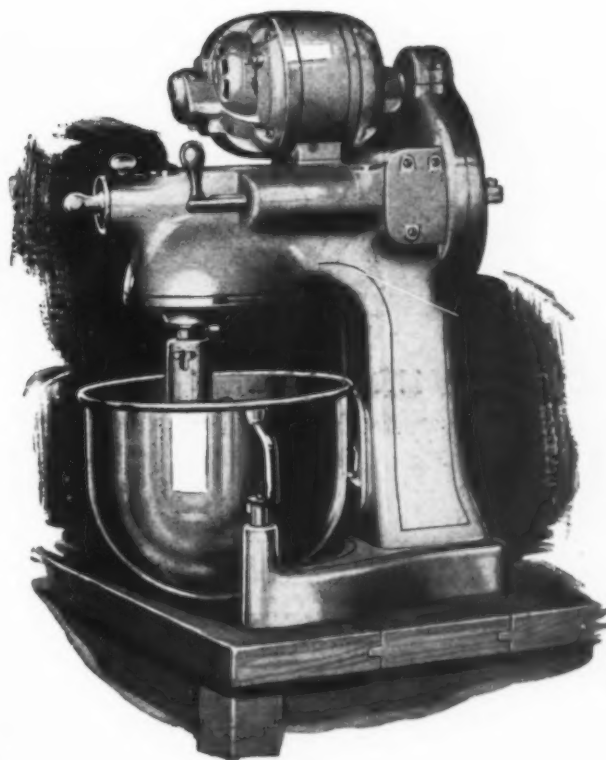
Rack size 29½ in. wide over all; 10 in. deep

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with the
**CENTURY
GIANT
15 Qt. Mixer**

The new 15-quart Century Giant is especially suited to work in hospital kitchens, for with it you can beat eggs, strain soups, prepare custards, fruit sauces, jellies, gravy stock, omelets, puddings, purees and salads; you can whip cream, freeze ice cream, extract orange or lemon juice; slice fruits and vegetables, mash potatoes, pumpkin, squash, turnips, etc.; mix mayonnaise and other dressings, and do many other tasks with great speed and simplicity. It is a quiet running, compact machine with unusual mechanical features.

See this Century Mixer at Booth No. 114,
American Hospital Association Convention,
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The Century Machine Co.

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OAKLEY, CINCINNATI, OHIO

For complete index of advertisements refer to the Classified Directory



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saved during an operation effects more than added service to the patient. When the Universal Cutter is used this saving of minutes and hours in bandage, gauze and cotton cutting means efficiency to the doctor, economies to your institution and minimum waste of materials. May we give you complete details?

UNIVERSAL CUTTER CO.

Mfrs. of Electric Gauze Bandage and Cotton Cutter
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Offices in All Principal Cities

ENDORSED BY USERS — EVERYWHERE

You too will find the high purity of our gases and the easy working and non-leaking valves much to your advantage.



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A synonym for the best there is in

NITROUS OXID
OXYGEN
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CARBON DIOXID
PERCENTAGE MIXTURES
OF CARBON DIOXID
AND OXYGEN
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Book Reviews and Current Hospital Literature

NOMENCLATURE OF DISEASES AND OPERATIONS

By T. R. PONTON, B.A., M.D.¹

Dr. Ponton, who is superintendent of the Hollywood Hospital, Hollywood, Calif., and a member of the committee on records of the American Hospital Association, has compiled a most valuable nomenclature on diseases and operations. He has taken seven years for this important work and this compilation is of such value that it is difficult to imagine any hospital being without several copies.

According to the foreword Dr. Ponton intends to revise the present edition from time to time, keeping it up to date for hospital use. In the back of the book are several examples of forms, such as admission cards, disease index, operation index.

The book is endorsed by the American College of Surgeons and is dedicated "To the program of hospital standardization carried on by the American College of Surgeons, under the able leadership of Franklin H. Martin."

A NEW MANUAL OF PSYCHIATRY

By AARON J. ROSANOFF, M.D., Formerly Clinical Director, Kings Park State Hospital, N. Y.

The sixth edition of this book which has just appeared is an up-to-date working handbook, and contains many additions to the text and numerous illustrations. One of the most valuable portions of the book is a glossary of technical terms, a feature that is always helpful in standardizing the nomenclature of mental disease. There is a clarity of style and an excellence in choice of material that combine to make the book a useful tool for anyone interested in the subject. The book is recommended for inclusion in the professional library of hospitals.

PROCEDURE BOOK OF THE METHODIST EPISCOPAL HOSPITAL, BROOKLYN, N. Y.

This is a paper covered book of 151 pages, prepared by the members of the various departments of the Methodist Episcopal Hospital, Brooklyn, N. Y. It was originally intended for the benefit of the student nurse, but has "expanded into a manual of the procedures, diagnostic methods, diets and treatments" used in this hospital.

Besides giving in detail the outline of work of each nurse, with the method of nursing and housekeeping procedures, it describes minutely the technique of both the operating and obstetrical departments; gives two pages to rules and regulations for use of radium; fourteen pages

¹ Physicians' Record Co., Chicago.

² John Wiley & Sons, Inc., New York, 1927.

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to drugs and solutions; twenty-six pages to procedures of the medical department.

The book is undoubtedly of value to the hospital for which it was prepared, and it should be of interest to other institutions for purposes of comparison and possibly as a stimulus to revise their own procedures.

It should also make hospital people pause and think. On the first page the nurse is told to rise at 5:45 a.m., and be in the dining room at 6:30, leaving her room tidy and her bed made. Is this small amount of bed airing in our schools in any way responsible for the illness all of them report?

One cannot help being impressed with the large amount of cleaning, washing of dishes, operating room basins and equipment, as well as other maid and orderly work delegated to the student nurse.

One wonders how there is any time for actual nursing, until it is discovered that the twelve-hour night duty is maintained and, surmising that the day is probably proportionately long, it is realized that hospital exploitation of the student nurse still exists.

The book should be carefully read by those interested in the preparation of the nurse for community service.

CHEMICAL LABORATORY MANUAL

By L. JEAN BOGERT, Ph.D., Research Chemist, Obstetrical Department, Henry Ford Hospital, Detroit; Formerly Instructor in Experimental Medicine, Yale Medical School and Lecturer in Chemistry, Connecticut Training School for Nurses, New Haven; Formerly Professor of Food Economics and Nutrition, Kansas State Agricultural College, Manhattan.¹

This book is intended to accompany Bogert's "Fundamentals of Chemistry" and undoubtedly will be of service to the inexperienced teacher of chemistry who hesitates to prepare her own outline.

The material is well organized; the laboratory equipment suggested is adequate but not extravagant; the simplicity of the experiments selected is wise, and the general directions are comprehensive and well thought out.

While a teacher of experience might object because nothing is left to the student's initiative, yet in a short course such as is given in many schools of nursing, the manual will be helpful in selecting from the vast field of chemistry the material that is essential.

LISTER AND THE LIGATURE

Compiled by the Research Readers of the Scientific Department of Johnson & Johnson, New Brunswick, N. J.²

This ninety-page pamphlet is published as a centenary contribution to the memory of Lord Lister. It gives the story of Lister's efforts to produce a catgut ligature, mainly in his own words, taken from his writings now scattered and somewhat inaccessible.

The introductory chapter gives data on the use of the ligature prior to the time of Lister; touches upon the antiseptic methods introduced by him and outlines the evolution of the modern system of asepsis as developed later.

A complete bibliography of Lord Lister's contributions to medical literature is included.

This little book is an interesting addition to the Lister literature that has appeared during the year.

¹ W. B. Saunders Company, Philadelphia, 1927.

² Johnson & Johnson, New Brunswick, N. J.



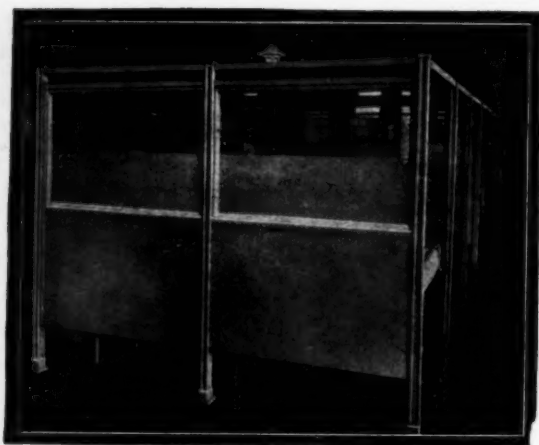
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Trade News and Publications

Hospital Food Service Equipment.—From Albert Pick & Company, Chicago, comes a booklet of twenty-one pages dealing with the problems of the proper equipment for the hospital kitchen. The booklet is well printed, beautifully illustrated, and contains floor plans for typical kitchens in hospitals of 40 to 50 beds, 75 beds, 125 beds, 150 beds, 200 beds and 500 beds. There is a list of the various problems that arise in connection with equipping a new kitchen, and these points will serve as reminders of the pitfalls to be avoided. The discussion as to what constitutes the best type of equipment and its construction will undoubtedly prove helpful to the hospital superintendent and the dietitian. Also included is a list of things to be remembered when buying the different items of modern equipment that constitute the hospital kitchen that has been planned along efficient lines, whether it be for a new institution or an addition to an old building. Copies of the booklet will be mailed to hospital executives upon request.

Portable Emergency Light.—Bulletin No. 955, describing the Roth emergency light plant, has been mailed to hospitals by Roth Brothers & Co., Chicago. This emergency plant, having a single unit light, can be adapted for service wherever a single unit light may be required. In use the light may be operated under normal conditions from the regular alternating current source of supply by means of a ten-foot cable and an attachment plug that can be inserted in any standard alternating current outlet. In the event that the regular current fails, the light will operate from the battery with which it is provided.

Pipe Coverings.—A folder containing general information, prices and other data concerning a new cork covering for cold pipes has just been published by the United Cork Companies, Lyndhurst, N. J. This covering is manufactured in three thicknesses, and a service organization has been provided to insure the proper installation of this covering. Copies of the bulletin may be obtained by writing to the company.

A Transparent Wrapper.—DuPont Cellophane Company, Inc., New York, has mailed a circular descriptive of Cellophane, a transparent, dust-proof product for wrapping food products and other merchandise. Enclosed with the circular is a sample of Cellophane and a return postcard which may be used to request free working samples of the product.

Refrigerators and Cooling Rooms.—The McCray Refrigerator Sales Corporation, Kendallville, Ind., has issued an attractive forty-eight-page catalog, No. 57, illustrating and describing its line of refrigerators and cooling rooms. Of helpful interest is the data sheet for determining the size of cooling coils required for the various sizes of refrigerators. Copies of the catalog are available upon request.